HIT Policy Committee Information Exchange Workgroup
In Person Meeting
Draft Transcript
March 15, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the HIT Policy Committee's Information Exchange Workgroup. This is a Federal Advisory Committee, so there will be opportunity at the end of the meeting for the public to make comment. A transcript will be made available and placed on the ONC Website. Just a reminder to workgroup members to please identify yourselves when speaking for attribution.

Let's introduce the members of the workgroup around the table, starting on my left with Kory Mertz.

Kory Mertz – NCSL – Policy Associate
Kory Mertz with ONC.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Jim Golden, Department of Health in Minnesota.

Josh Seidman – ONC
Josh Seidman, ONC.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Walter Suarez with Kaiser Permanente.

Deven McGraw – Center for Democracy & Technology – Director
Deven McGraw with the Center for Democracy & Technology.

David Lansky – Pacific Business Group on Health – President & CEO
David Lansky, Pacific Business Group on Health.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Micky Tripathi with the Mass eHealth Collaborative and the chair of the workgroup.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Farzad Mostashari, ONC.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Claudia Williams, ONC.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin
Dave Goetz, Ingenix.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Steven Stack, American Medical Association.

Hunt Blair – OVHA – Deputy Director
Hunt Blair, State of Vermont.

Sid Thornton – Intermountain – Senior Medical Informaticist
Sid Thornton, Intermountain Healthcare.

Judy Sparrow – Office of the National Coordinator – Executive Director
We do have a number of workgroup members on the telephone. Connie Delaney, are you there?

Connie Delaney – University of Minnesota School of Nursing – Dean
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Ross?

David Ross – PHII – Director
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Is anyone else on the telephone?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Just so you know, George Hripcsak is on the phone.

Judy Sparrow – Office of the National Coordinator – Executive Director
And George Hripcsak. All right, well thank you and I'll turn it over to Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Good morning, everyone. Thank you very much for attending the Information Exchange Workgroup's session today. We're focused on a very critical activity today, to start our own deliberations regarding the information exchange and the connection between the meaningful use stage two and stage three recommendations and the information exchange capabilities that are going to be needed to power some of those objectives. Today we've got a variety of things that we're going to try to cover. One is looking at the objectives themselves. The stage two recommendations that were made by the Meaningful Use Workgroup were posted for public comment and the public comment period is over now but we're going to be looking at those recommendations that were out there for public comment and providing our own perspective on those.

The second thing we'll take half an hour to an hour to discuss is the quality measures, which are another important part of the recommendations. Then finally, we'll spend a little bit of time discussing this concept of qualified entities as it relates to health information exchange, and that's arisen in a number of different areas—from the Governance Workgroup, Meaningful Use Workgroup. It was a suggestion in the recommendations that perhaps that's a way of thinking about the ability to demonstrate health information exchange capabilities through the use of so-called qualified entities. I'm not going to even try to define that right now, but leave that for the discussion later.

What we're going to try to do is go through the stage two objectives conversation up until lunch and then a little bit after lunch, and then starting at about 2:30, if we can stay on track, we'll go through the quality measures conversation and the qualified entity concept. Our goal for today is to prepare comments for the Meaningful Use Workgroup in time for an anticipated April 5th meeting that they have where they're going to be reviewing all of the public comments that came through the public comment period. So they had a set of recommendations that were out there, and I think they're still available on the Website, and those are frozen from the perspective of the Meaningful Use Workgroup has stopped to allow that public comment process to take place. Then right now I think CMS is going through the public comments, will analyze them, provide them back to the workgroup, and that will be their opportunity then to take all those

comments. That's why it's a perfect time for us in the Information Exchange Workgroup to be able to offer our comments as well, because they have paused in their own deliberations. I think, as we've discussed with the leadership of the Meaningful Use Workgroup, it would be most helpful for us now in that timing to be able to provide our comments as well.

Our goal here is to walk through the various elements, and ONC staff, in particular Kory Mertz and Claudia Williams, have just done a fantastic job of trying to distill from those recommendations which specific objectives, meaningful use stage two and stage three proposed objectives, have a significant information exchange component. What we've done is they've distilled that into the presentation that we're going to go through and we're literally going to walk through them objective by objective. We've got some key framing questions for each one, but obviously, the floor is completely open to thoughts that anyone in the workgroup has about different ways to think about it, different things to think about.

I think the goal here is, again, to start to think about our comments that as a workgroup we're going to want to formalize and then I think be able to present or deliver in some way to the Meaningful Use Workgroup in anticipation of April 5th. We're not going to resolve all the issues here, I think none of us should pretend that, but what we want to be able to do is get significant thoughts on the table, use this unique opportunity to have face-to-face conversations. We do 95% of what we do by phone, so I think being able to use this opportunity to have face-to-face discussion of what we think are the most meaningful points, and then we'll certainly have, between now and April 5th, via phone and e-mail conversations to try to crystallize these into a more formalized set of comments.

In terms of how we're going to go through this today, the first part, as I said, we've got the three topics, the objectives, the exchange implications of the quality measures, and the qualified entity concept. We've got near term and longer term considerations here. One is the near term is more about stage two, so there are some firm stage two recommendations that we're going to be looking at. Some of the questions are what are the assumptions about exchange capability that underlie those stage two recommendations? In some cases, the stage two recommendations are explicit, to the extent that they say that the use of a particular type of technology or something specific in the way of infrastructure would be the demonstration of a meaningful use objective. In other cases it's more about an assumption that a particular clinical function would be performed as a part of a meaningful use objective, where there is an implied assumption about there being capability underlying.

So that's one of the things we want to be able to go through is to try to understand that and then ask ourselves is this the right set of objectives? Are there any objectives that we might think are missing? Then finally, can the HIE infrastructure and the market as we know it right now support what's either the explicit or implied information exchange capability that underlies the stage two recommendations.

The longer term perspective and the one to keep in mind, although we have limited ability to drill down into it, is stage three, and as we'll see in the recommendations for certain elements the Meaningful Use Workgroup did lay out some higher level stage three objectives, but I think one fundamental question for us is, what's the bridge? How is stage two the bridge from where we are today to what might be the longer term objective in stage three? I think it's a particularly important issue because some of the signature ONC programs out of HITECH, namely the Beacon program, the state level HIE program and the REC program, actually end between stage two and stage three. That concept of the bridge is actually vitally important as we think about that. Because to the extent that those programs can help lay the foundation for what will hopefully be a smooth transition. I know I like to think of the escalator, can lay that escalator so that people can move smoothly to stage three after those programs have ended but they've laid the foundation for it, is very important for us to consider.

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... to amend your comment in one way and say that the funding for the program is ending; the work of the program presumably will carry forward.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, thank you. I completely agree. I think that's a very important point. It's the objective of all of those programs, that they actually do sustain themselves. Thank you, it's a very important point.

With that, let me actually turn it over to David Lansky to see if he has any other thoughts, and then we'll begin our agenda.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Micky, and thanks, all, for coming. I think you summarized the meeting really well. The only thing I'd add is that we are doing this within the larger context of health reform and the Affordable Care Act and HITECH. Some of the requirements, I know in the meaningful use process and the quality measures process we're aware of the fact that the tools we are building, both the infrastructure data tools and the measurement tools, will be used by many other programs. So we're not working within an IT bubble, and part of that, for example, the ACO program that eventually will be unveiled to us, both in a CMS ACO program and then commercial uses of ACO, there will still be requirements for information sharing and for managing care across a continuum that's more than a single EHR setting.

So the information exchange work we're doing here, I think we have to be cognizant we're trying to pull capabilities in the whole health system forward to support a variety of policy goals and making sure that we set forward objectives for meaningful use and quality measures to go with them. Which facilitate everybody building out the infrastructure that will support care coordination and care across the continuum for the larger purposes of health reform is part of what we have to keep in mind. So we're not only optimizing the IT build out, but we're optimizing the capacity of the system to manage care. I think we'll do that as we go through these, but it's always ... because I think we're also cognizant of the fact that we're asking a lot of people, a lot of the industry, and we have to find a balance between pulling people towards capabilities we're advocating and respecting the fact that it's expensive and difficult to do it. So I hope we'll take each of these objectives within that framework as we go forward. Thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that next on our agenda is Farzad Mostashari. Do you want to give us some thoughts?

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
I want to thank everybody for the hard work they do on behalf of the country really and our personal thanks to you from ONC for all the hard work you and many other of the workgroups of the Health IT Policy and Standards Committee do. It really makes our policies, I think, not just more transparent but better. We have made extensive use of you. We hope to continue to do that. Really the work and the thinking that has to happen is too broad and big for any one group, any one body, whether it's ONC or even the fact that as a whole the Policy Committee or the Standards Committee as a whole to do. So each of the workgroups that have been working, whether it's the Meaningful Use Workgroup, the Health Information Exchange Workgroup, this one, the Quality Measures Workgroup, the PCAST Workgroup, the Governance Workgroup, Privacy and Security Tiger Team, each has been doing really critical pieces of this. These pieces really do fit together and they come together in meaningful use and actually the three linked rules that will be coming out in ... rulemaking we hope by the end of this year will be where all of these pieces are put together, where it all comes together.

There's an enormous amount of work that has to happen between now and then to realize that. I just want to put the work that you're doing within some of the context of those other activities, because they are so intertwined. The Meaningful Use Workgroup I think is setting the broad parameters and vision for how the different pieces of the meaningful use rule will fit together. But they have, as Josh will talk about, quite consciously said on the piece about information exchange we really look for the Health Information Exchange Workgroup to tell us not only where we want to go, but how fast we can push and what is the context within which information exchange and information exchange requirements has to occur.

That has always been, I think, the critical role that this workgroup has served and served well. Is understanding at a very real concrete level not only the benefits of each of the information exchange functions from a very clinical and operational and functional point of view, but also being able to abstract up to what is the full picture within which that information exchange occurs. What are the policies,

whether it's at the national or state or commercial level? What are the business cases that are impacting this? What are the standards? What are the tools that are going to be needed, and importantly to give us advice not only from a regulatory perspective but from a programmatic perspective and from our bully pulpit perspective and for the states in their policy actions of what they can do to make it better. That is, I think, critical to not just identify, diagnose where information exchange functionally is falling short, but also to be able to provide prescriptions for action. Meaningful use is one lever. It is only one lever that you have recommended to us over time in terms of implementing that.

In terms of information exchange, the eye on the prize is clear, the goal, the North Star that we're striving towards, that information follows the patient where it needs to go irrespective of organizational, geographic, or vendor boundaries for that person's care. The challenge is really how do we follow the second principle we always talk about, the feet on the ground principle. How do we get there from here and how do we do so in a way that doesn't forestall innovation and future possibilities. What can be done and how quickly. We want to have an escalator path from meaningful use. We want it to be ambitious, but achievable. How can we, and I think the discussion today is going to be critical in helping frame, how can we push forward on the escalator, push upward, ever upward, while still remaining connected and to what's actually feasible. So how can we make it ambitious but achievable, and really focusing on where there's the greatest value potential.

Then, innovation, we have another workgroup on the PCAST Report that really has its eyes on the prize of learning healthcare system and on innovation. I think it's worth noting that for information exchange there are many use cases that we have considered over time, and they roughly correspond to our meaningful use framework. There's the information exchange that a provider needs or a hospital needs within their walls to take better care of the patient, to have more quality, more safety, more efficiency, having laboratory values in structured format, having the prescriptions, the medications, the laboratory data and so forth. So there's that aspect of information exchange.

There's the patient engagement, and now not just giving people information, but them also being able to have communication, bilateral messaging and patient observations. There's care coordination and referrals flowing. Then there's the population health purposes, both for reporting to public health but also merging into the concept of a learning healthcare system, whether it's around quality measurement, whether it's around research, whether it's around being able to truly understand not just individual care but the group's care as a whole. All of this within the framework, of course, of making sure that we protect privacy and security as we do all of this, that everything should be done consistent with that overarching dictum.

So you have a complex challenge and I think the work of the committee as a whole is going to be critical to helping us put the pieces together. Not just for meaningful use stage two, which is the task at hand, but also to make sure that the extended vision of the future, that what we put in place now and the direction that we're moving now is not going to require a major course correction as we get into stage three. How is that we can build the basic building blocks and establish the basic infrastructures, the basic exchanges that can help us build towards the future without forestalling future possibilities that we need. So we're very glad to have you thinking about this with us, it's a complex issue, possibly one of the most complex faced by ONC and CMS in formulating the rule, and we are very happy to have you engaged with us. Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, Farzad. I think Josh is going to give us some comments.

Josh Seidman – ONC
Yes. I'm going to try to put the process into context. I staff the Meaningful Use Workgroup. There was a lot more luxury of time in the process in developing stage two recommendations for the Meaningful Use Workgroup, so they were able to hold half a dozen hearings last year. Several of those were relevant to information exchange. In fact, they all touched on it in some way. There was one full day hearing on care coordination which discussed it extensively, as did the public and population hearing. Then they hold four months of deliberations on potential stage two objectives for meaningful use. The way that they

set out that task was they said where do we want to be, they called that stage three; where we are now is stage one; and then stage two is what is the stepping stone to getting there.

That was the process that they went through, and so they did actually suggest what potential stage three objectives were. When they released their Meaningful Use Request for Comment in January they did actually put those stage three objectives in the RFC, although they did note that they weren't really looking for feedback on those stage three objectives, they were really just to give people some guideposts. But I think the important thing is to try to, as far as I described, what is the process for going up the escalator and how can we get to where we want to be from where we are now.

When the Meaningful Use Workgroup put out its recommendations, as Farzad mentioned, they noted that there were certain areas for which they were specifically leaving room and expecting input from the other FACA workgroups. So Information Exchange, the PCAST Workgroup, the Privacy and Security Tiger Team, and the Quality Measures Workgroup were all areas where they had some things in there but they basically said we're deferring to the expertise on those workgroups to get some more specific guidance and expertise.

The process where we stand now is that as of February 25th the 45 day public comment period on that Request for Comment is closed. The staff is now processing, synthesizing all of those comments and bringing that to the Meaningful Use Workgroup in the next couple of weeks. At the April 5th all day meeting of the Meaningful Use Workgroup, they will be discussing basically the synthesis of all of these comments. Even though we're expecting comments from these workgroups, and certainly there were a lot of comments that came in through that process related to information exchange, so any input that is available at that time would be great. Continuing through April there will be an opportunity for those workgroups to feed in, because the Meaningful Use Workgroup will first be presenting the report from that Request for Comment at the April 13th Policy Committee meeting, but then it will be presenting its recommendations at the May 11th Policy Committee meeting. So that's when there will be a full discussion of the stage two proposed objectives that the Policy Committee will recommend, and it will make its final recommendations based on its June 8th Policy Committee meeting.

That serves as the process. I guess I would also note that I think, as it was also stated before, that there really are a lot of intersections of information exchange with many of these workgroups, certainly the kinds of things that David Lansky, who chairs the Quality Measures Workgroup, is working on, and really many of the other workgroups. Information exchange is so central to many of the things that we want to accomplish, so we do appreciate your input into all of that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, Josh. I am now going to turn it over to Claudia Williams.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Thanks, everyone, I know it's always a feat to get yourselves to D.C. and spend a full day on this. I know how much we benefit from the folks who are around the table sharing their thoughts, and also those on the phone. Did we go to the phone to get peoples' introductions? We did already, okay. Before I jump into the slides, I know one question that's come up, and we have just the right people here, Judy and Josh, is in what form we should be bringing forward the recommendations and whether it should be a letter that just gets shared or an expectation that we're actually participating in the hearing. So it might be good just to spend a minute on that so that we understand how we're going to be taking this work forward.

Judy Sparrow – Office of the National Coordinator – Executive Director
... is probably the best vehicle. It's more explanatory and you can use that letter to flesh out your logic.

Josh Seidman – ONC
I think, importantly, it can be very specific and I think that having documentation is very helpful to the Meaningful Use Workgroup and ultimately the Policy Committee's deliberations.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Josh, that April 5th meeting, is that a public meeting like this, or is it actually a hearing where they're going to be—?

Josh Seidman – ONC
It's a public meeting like this one.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Would there be opportunity during that meeting to do a presentation on the IE Workgroup recommendations? Or, the expectation is that they will just be collecting all the input from all the other workgroups and discuss it during the meeting without each workgroup presenting, because that would probably be a lot of time.

Josh Seidman – ONC
My sense is that in that April 5th meeting probably having the documentation will be the most efficient way of dealing with things. But if there are specific things, I think that there certainly would be opportunities for further discussion.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Great. I think one thing that we discussed also is that this group may have specific recommendations on measures, on the concrete thresholds, etc., or our input might be in the form of comments on readiness of participants and information to inform the deliberations. So we should absolutely be putting forward clear suggestions in those areas where we have them, but even if our conversation just unearths things that should be thought about, things that should be considered, that's of great value and we should definitely be bringing that forward as well, I think. So we'll be trying to capture not just those clear cut go this way or that, but also the nuance of the conversation, the kinds of issues that are raised, since many of those folks aren't here and present today.

What I was going to do is provide the transition to the work at hand, which is to talk about stage two. We thought it would be helpful to give you an update on the state HIE cooperative agreement program, just as one among many framing elements for this discussion, and also talk briefly about the status of direct and where we see that being implemented. Then finally just lay out a set of, not that we need to reach conclusion on them, just to lay out a set of framing assumptions for our conversation about stage two.

I look around the table and see Jim, and we have at least two of our HIT coordinators represented here, the state HIE cooperative agreement program is a half billion dollar program that has funded every state and territory to rapidly enable health information exchange capacity for the state. Realistically, what that means is a need to really focus on achieving the basic information liquidity needed for the kind of exchange to support patient care, clinical summaries, lab results, ePrescribing that really support what's laid out in stage one. The reality is that even for those basic functions, for that basic data that's so foundational, so things like quality reporting, identifying errors, making sure folks have good transitions, there's very uneven availability of that information across the country in electronic form.

The first thing we said for everyone is we have to get information liquidity up to a point where indisputably for every patient, for every transition, there's a way to share that basic clinical information rapidly, easily, cheaply, and ubiquitously. In addition—and as a corollary to that first—we know that there are places where exchange is occurring, whether through IDNs or through newly emerging ACOs or through existing exchange infrastructure, that might have really preceded our work. But there are also, in almost every state, big areas of white space where there isn't as much business motivation. There isn't as much existing a case to be made for connecting, let's say, to a critical access hospital or a small independent lab. There's a particular burden to use the public funds to make sure that no one's left behind, whether a small provider or a small hospital, or folks that are really important participants in the information sharing ecosystem.

So data liquidity with a focus on the small guy is the first theme. A second is this concept of core infrastructure that can serve many exchanges. In some cases, like in Vermont we have the existence of

a really robust and very supported by the stakeholders public utility that's serving everyone. In other states, we have multiple exchange entities that need to be connected and be using the same standards and the same policy assumptions so that we can have interoperability across the state. In either of those cases, there is often a set of core infrastructure. We spent a lot of time talking about provider directories as one example, EMPI might be another one, authentication might be another one, that can really serve as a benefit to many different exchange entities and allow for that kind of thin layer of interoperability across the state. So that's another area of significant investment going on right now in states to be sure that those core pieces are available and can be in service to exchange across the state.

Finally, as we're building out information liquidity and the core infrastructure, we need to be doing it in a way that builds to the kind of capacity that we need. There are places in this country where you can now query a patient's records and bring back the information that you need at an ER, a care summary, even where you don't necessarily know the name of the doctor that they saw last. But we need to be thinking about even if there's a state that's still in the stage of really needing to build a basic data liquidity, how can it do it in a way that future proofs it to allow it to move into the phasing of discovery and population level analytics that it will need to do over time. We are, in many cases, working with states around a phased approach that can describe how the functions and core services you're using and building now can also serve those other purposes that you need to build out over time, especially for patient information discovery and population level analytics.

We're also seeing that even as we're progressing with planning, every day new developments occur in the technology space and in the market space. These public investments need to be made in a way that's nimble and responsive, but not completely reactive to every new announcement that's made. Build from the innovations that are occurring within the market and the existing exchange capacity in states that may not be publicly funded, but needs to be connected and needs to be part of the whole story.

Let me actually skip ahead to this slide. The direct specs are now pretty much in final form and we're seeing very rapid adoption by a variety of different vendors—HIE type vendors, EHR vendors, PHR vendors. Also in more than 20 states there is some kind of planned implementation, whether a behest for certificate authority or using Direct, again, to lower the cost and complexity of these basic exchange tasks. This is a somewhat dated slide, it's probably about a week or two old, but on the Direct Wiki there's an actual ecosystem page that gives the most updated information about the vendors that have come forward and said, yes, we are planning deployment. Now, that does not mean that you using your Cerner system, there is a deployment cycle that we're going to be working through and living through over the next year or so, but I think you can see that there's very widespread market adoption. We've already seen care summaries exchanged in Rhode Island, immunization data exchanged in Minnesota, and we'll, I think, be seeing a lot more announcements of that type over the next couple of months.

Now, going back, just a quick level set around Direct. It's openly available, open source protocols relying on existing standards to securely message, securely transport health information. It is the secure transport piece of it. We are now working through the S&I framework initiatives to also do the same kind of in-depth work around some of the content pieces and the packages that need to be used with Direct, whether to send a lab result or to send a care summary, etc. But just what is it? It's an openly available protocol for secure messaging. We've seen already very clear use cases around sharing care summaries, sharing clinical summaries, immunization results, and importantly patient data. One of the PHR platforms has said that any individual using their service will get a Direct address and can receive information that way.

One of the concepts embedded in Direct is this concept of a health information service provider, which would be your service provider to use Direct. In some cases, providers will be directly using their EHRs that will have enabled the protocols. In other cases, you might be using a separate HIST intermediary that's using those services for you. I think there's a lot of work going on right now among the folks that are launching and deploying about what the business model is for the HIST, how it operates, how it interacts with other HISTs. There is some great thinking and writing, again on the Direct Wiki, that I think will be informing our policy work going forward.

One of the core assumptions that's been embedded in this work and that's really benefited, I think, from Deven and Paul's great efforts on the tiger team, is what should be the policy baseline assumptions. There has been a lot of back and forth with the tiger team to ask the question what should be the policy infrastructure that we need for this. I think, and Deven can clearly speak to this much better than me, but I think one of the core assumptions is to the extent that information is getting shared in encrypted form, where there's no PHI being shared in transport, that that operates within an existing HIPAA construct and wouldn't necessarily require additional patient consent as it's moved. So one of the things I think we're going to be seeing as we see these exchange entities develop is the kinds of agreements that providers will have with their HISTs. But then the assumption that information can flow from one EHR to an HIE to other folks using the same protocols without necessarily having bilateral agreement between every single one of those endpoints.

That was just to say, I think we'll be using some of the terminology of HIST, etc., so I wanted to be sure that folks saw where the origins of that were and had an update on Direct implementation in general. We just thought it would be helpful to lay out just some assumptions about where we are today, where we'll be in six months. We can certainly discuss this, but the point is not that this is anything we're taking forward, but can just be used as framing for the discussion about stage two as we move into the measure by measure going through the day.

One, I think, is the assumption that there will be very wide scale, if not ubiquitous availability of directed exchange capabilities to perform the kinds of exchange that we talked about in stage one, lab results, care summaries, public health information, etc. That related to that that there would be availability of fairly low cost options, whether sponsored by the state or in the market, to perform at least the transport part of that function. I think also that as we move forward with NW-HIN governance, consistent with the recommendations that came out of that workgroup, that there might be this conception of qualified entities who meet the basic interoperability and privacy and security requirements of NW-HIN governance, and that's yet to be determined.

But that conception is one that we can link our work to and that there will be some of this core infrastructure, whether EMPI or some directories at an individual level, but that those are proceeding at different paces and rates in different parts of the country. So there's not complete uniformity right now in availability of all of those core pieces. And that related to that, there are pockets, and in some places very deep pockets of capability to support discovery of patient records, but that again there's different scales of development, different rates of development in different places.

I think one area where we've seen, and we will continue to see very rapid movement, and I think we can be asking how to even push that across the line faster, is in lab exchange. I think that's driven by a number of different things, policy changes, for instance, around CLIA, but also a very strong focus within the state HIE program on enabling lab exchange. I think, frankly, in some cases Direct will be a big enabler and in addition the work that we're doing around the S&I framework to come up with value sets and come up with ways to make that lower cost, cheaper and more accessible. I think we will hopefully see that all of those things knitted together will create real momentum for the availability of electronic structured lab results that are so foundational to so much of what we're trying to do in meaningful use.

I think the public health infrastructure piece, there's the question of whether you can send and then there's whether it can be received. Again, we have a great core of folks on the public health side today. We have Jim Buehler, who will be on the phone, Seth Foldy will join us later, Jim Golden, Jim Daniel, who's our new public health coordinator on the ONC side. So I think that's an area where as we get to those measures I think we'll see that one of the lists we have from an ecosystem standpoint is how to pull progress along from the receiver end of the information so that both sides can be met there.

Just in terms of framing our discussion and thinking about where we are, maybe we should pause. We've covered a lot of ground over the last half an hour or so, so maybe just pause for discussion, addressing Farzad's comments, or Josh's, or mine.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I think that would be great. First off, thanks, Farzad, Josh, and Claudia. In particular, I think, Claudia, you're going to be with us for the entire day, right, but Farzad and Josh I don't believe are going to be able to spend the entire day. So I'd just like to pause here for any discussion, in particular any questions you might have for Josh or Farzad while they're here.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin
I'd like to clarify. You mentioned six months, Claudia. Do you mean at the start of meaningful use for the assumptions to be in place, from the start of stage two?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Actually, let me push on ahead. I didn't want to go over these because I just think trying to get ready for where will we be at the beginning of stage two. These slides are meant more as a resource to all of us in our discussion and they go through system updates and timeline pieces to keep in mind, both for meaningful use and for the life cycle of the actual programmatic funding.

M
I'm sorry I missed the introduction this morning. I also wanted to address the assumptions around the Direct project itself. I served enthusiastically on the User ... Workgroup and we have several people at Epic who continue to help flesh out the specs and participate in the pilot programs. I would question really strongly the idea that we will have ubiquitous direct exchange in the sense of the Direct project in the next six months or a year. The specs are still not complete and the current implementations are in pilot. We are one of the EHR vendors who is putting the specs into our new version of the software, which will come out several months from now. With the implementation of the specs comes implementation of particular kinds of workflows within the software that aren't specified by the specification at all. Then as we know, there's sometimes fairly long, sometimes a couple of years of deployment life cycle that goes on, and that was the topic of our public comment for the stage two meaningful use recommendations.

I think that for stage three it's absolutely appropriate to think that we can have infrastructure in place that we would have products that would support those specs and that we would have had some good results from a variety of pilot projects and real world production implementations. I think it's jumping the gun a little bit to suggest that in stage two we would actually have enough implementation of the Direct specs to require it for meaningful use. We haven't even required specs that have been around much longer and have been proven to a much larger degree, such as the IHE XDS.b specs for a variety of use cases that are actually pretty important, like the emergency department pull from another provider. Anyway, I'd like us to keep in mind that those assumptions are perhaps not entirely probable.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Thank you for that real life perspective in terms of how long it takes to not just have protocols enabled, but actually be out in the field and used and get to the point where a large percentage of the transactions can be conducted using those protocols. I think there are a lot of steps between now and then, and we've made incredible progress, from 90 days from vision to initial set of protocols, 90 days from initial set of protocols to working prototypes, 90 days from prototypes that folks like yourself have participated in, to getting into pilots. A lot of work remains. I think what is encouraging is the near weekly addition of organizations and vendors who plan on embedding those pretty simple, thankfully, protocols within their product. I do want to draw this group' s attention from a process point of view to the difference between certification and standards and the certification standards rule and the recommendations for that, and the meaningful use requirements.

The Policy Committee will give its recommendations in terms of what should be included in meaningful use. There's a separate process for having taken those recommendations from the Policy Committee, taking them to the Standards Committee to say, now what are the implications for the certification of electronic health records and the standards for those. This group may say "x" percent of referrals should be accompanied by a summary of care record electronically, not on paper, and then it would then be the Standards Committee's responsibility to say what should be the standards for the summary of care record. Are we ready to say it's this or that? What are the standards for the transport, if any, that we

would want to use and what would be the implications for the certification of records? So somewhat different discussions, one leads to the other, but we're not expecting this group today certainly to decide whether the Direct protocols are going to become part of the standards and certification requirements for electronic health records in stage two.

M
... I do think it's important, though, as a framework conversation with the parameters that exist in the world today.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, Steven?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thank you, Josh and Farzad and Claudia. I'm a hospital based physician, for those on the phone, an emergency physician, and I'm with a health system that's part of a larger health system at 72 hospitals across the country. When I first began my involvement in these workgroups, which is, I'm guessing, two and a half years on now or so, they had made the decision that they couldn't go forward with implementing because they didn't have the financial means. It would ruin their bond rating. They have since revisited that and are now going to do, I guess, a billion and a half dollars of investment across 72 hospitals to implement, over the next few years.

What I'm struggling with a little bit is the rollout for that, which is going to be one that really hits really aggressively, is going to begin next year at some point. So they're in the process right now of writing order sets for the physicians to use and we are going to be, in 2012 and 2013, really at the stage one level of execution, getting processes redesigned to use the technology, getting people collecting data in structured format. Apart from whether the infrastructure is not ready for information exchange, which I think is another substantial discussion that we'll focus on today probably, I think there's a mass of the provider community who's really going to be sincerely trying to implement but really at the stage one implementation. Because the cost and the effort and the lift is so enormous just to redesign all those processes.

I think the vision for where we want to get with stage three, I give a qualified or hedged opinion that I think that's a good vision because I think that's where we want to get for the benefit, but I wonder about the slope of the curve from one to three. Because we have to remember that ultimately the program, the short funding frame that we have for these programs is, in some ways, a carrot, stick kind of approach for the provider community to adopt the technology and to use it. I don't think anyone, not ONC and not Congress or others, and certainly not the provider community, wants to get somehow stuck where they fail to fulfill what the requirements are that we set for two on the way to three, because it just takes longer than the time has been allowed, if that makes sense.

Farzad Mostashari – ONC – Deputy National Coordinator for Programs & Policy
Thank you, Steven. A couple of things. One is the slide that's up on the HITECH timeline, it says "Meaningful Use Stage Two (Current Plan)." The reason why those parentheses are in current plan is there is because there has been a lot of feedback on the part of vendors and providers regarding the short time frame between when HHS would publish a final rule on stage two. And when, according to the current framework set up in the final rule for stage one, the vendors would have to get their systems updated, they would have to get certified, they would have to roll out upgrades to the hospitals, and the hospitals would have to start using them meaningfully within a very short time frame. That's something that we've heard, and we are, and I think the Meaningful Use Workgroup, will be considering options for making it, again, ambitious but achievable on that. So that I think will play somewhat into the discussion you have.

But what you're bringing up is in a sense a bigger point. Where it's not just the, as we call it, the ecosystem that matures over time and the greater readiness of trading partners, whether it's labs or pharmacists and so forth, to participate in electronic exchange. There's also an individual level escalator that every group that enters, entity cohort that enters into the adoption process must go through. That's

partly why, again, the framework set out in the stage one final rule said if you are entering for the first year in 2013 you don't have to go to stage two, you start with stage one. I think that provides, again, an individual escalator within the broader escalator that we're discussing here. So it is a good point that while we're discussing here what should be in stage two, stage two may not apply, or at least some of the criteria that we lay out here may not apply to someone who is entering in for the first time in 2013.

M
....

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think that's ....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So individual escalators in the big escalator, got it.

Deven McGraw – Center for Democracy & Technology – Director
Micky, you're in the wrong town for the escalator analogy. In fact, if we can ... into this we've got to pass it on to metro.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I was actually thinking about that as I made my way here from the airport. Are there other thoughts, anyone on the phone, before we move to the meat of the agenda here? Okay. Oh, I'm sorry.

Sidney Thornton – Intermountain – Senior Medical Informaticist
I just want to respond to Claudia's comments about how we move forward for the more advanced functions. Our observation is we have tried to do that with our trading partners using legacy standards, but we have always underestimated the amount of effort and resource around working the exceptions, so issues around data integrity. So I really want to underscore what Claudia was saying about these other technologies around EMPIs, around the directories, that facilitate that, particularly as we look toward being able to find data across systems. If we cannot disambiguate the providers and the patients effectively it becomes unsustainable, and just from our experience even where we have a relatively closed population that we're trying to exchange that is always underestimated. I'm wondering as I look through these in our recommendations if we have ample or sufficient direction on how we will work those issues of data quality.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think these comments have really highlighted the triple lives we want you guys to play. In other words, we really want to dig in to stage two and provide substantive and thoughtful comments back to the workgroup, but we, on some level the progress in the system and the readiness of our ecosystem rests on our shoulders as implementers, as EHR vendors, as HIE leads in states. So we are also asking you to have another view of this conversation, which is to say where are your worry points about stage two or even about stage three. As we progress with our conversations this summer and walk through some of the use cases that we have already laid out in stage one, we'll be asking you to come back to those worry points and help us talk about solutions. How do we move as rapidly as we can to have disambiguated patient identity? That's perhaps not going to be a stage two requirement, but we need it squarely on our table as we move into our discussion this summer. So if you can keep those two conceptions of our conversation at the same time, the comments we want to take forward and the issues we need to quickly and rapidly address this summer as we move through our broader discussions about what progress we need to make, I think that would be great.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
If I can make a comment, I thought the question that Steve had was going to another aspect of this, which is separate from meaningful use. Meaningful use is about EHRs and about how they interact and all that. It seems like another opportunity that we have with this particular workgroup, Information Exchange Workgroup, is to look at the state HIE cooperative agreement and the activities that states are going through with their HIE experiences. To look at specific critical points, like, for example, we started with

provider directories as one of the elements, but it seems like there are these other elements that are critical like the EMPI and the data repositories. These kinds of elements that are part of an HIE, as part of their eInformation Exchange functions, and that facilitate ultimately the information exchange.

So it seems to me that we have that opportunity of once we're done with the meaningful use stage two and three, we can begin to look at these other critical points of development of the information exchanges in states that are foundational and that are still a source of challenge for many, if not all, of the HIEs. So it's like once we're done with the meaningful use over the next month or so then we can go back to look at what are the critical elements on the state HIEs that need some more guidance, I guess, and more definition. I don't know if that is part of what you were looking for.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, Walter, for your comments. I think to Claudia's point, there is these two tiers that we're working on here and once we get to the end we'll talk about the next steps on the agenda for the workgroup going forward. A part of it is going through transaction by transaction over the course of the summer and I think that's where some of these other issues can come up. Right now we're focused on comments for the Meaningful Use Workgroup, but that is not to have that replace considerations of the other levers, the broader spectrum of levers that we have. I think we want to make sure that to the extent that we identify any of those today, that we keep track of them so that as we go through this following April 5th meeting we can address them through whatever levers we think are available to ONC and the federal government, if that makes sense.

Great. Let's now transition to the meat of the agenda, and I'm just checking the time here. It's about five past ten. We're actually ahead. But I'm counting up how many of these things we have to do in the time that we have and thought that we were already behind. I'm on slide 13. What we want to do now is actually dive down into the various elements and really have specific conversations about the elements. It will be a little bit of a, I was going to say a forced march, but it's more like a forced sprint, because what we want to be able to do is we have, by my count there are about ten of these that we want to try and cover before lunch. If you just do the math that means we have to move pretty quickly, something like ten minutes each on average if we're going to do that. Obviously we want to make sure that we get the issues on the table. But I think we'll all be doing a very good job if what we're able to do is look at each of the issues, try to get our arms around whether what we think are the salient issues. And perhaps if there are some that we think are okay from a workgroup consensus perspective and don't have huge issues, being able to move quickly on to the next one so that we have adequate time for the ones that might take a little bit more thought and consideration.

For each of them, and what we're going to do is divide them up, we've tried to leave the public health ones. There are four public health objectives that we've put at the end because I think some of the public health folks aren't going to be able to join us until right after lunch. So we've intentionally just put those at the end, and what we want to do is quickly go through with each of them asking ourselves a set of questions.

One is, what exchange infrastructure is required to support the objective, which is a little bit of level setting and kind of what Peter and Sid were already pointing out, as you're cutting across. Anticipating that maybe there's some sort of level set expectations we might have to have here about what we think is in place today and what can be reasonably expected to be in place in the near future. Does that required infrastructure exist or will it be available for stage two? Is it the right objective, perhaps just asking ourselves the question of aside from whatever the infrastructure is, do we think that this is an appropriate objective? Is it the right level of stringency related to is it too challenging, not challenging enough? We want the challenging but achievable kind of objective that Farzad and Claudia pointed to.

Then finally, are there any objectives that we think should be added? Was that you laughing, Deven? This is a wide open consideration here and I think it's our opportunity to give a casting the net as broadly as possible kind of perspective to it if we think that there are things that really aren't there. I guess to the last point we could consider suggesting removing an objective as well, I guess in exceptional cases is probably the hallmark point there. But certainly all considerations are on the table for us here.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Just as a, and we'll see this in a minute when we look at the slides, and I know this is already probably burned into your brain, but there's a couple of ways in which an objective that was in stage one might evolve in stage two. One is it could move from menu set to core, if you remember, the menu setter optionalities across them. Another is that the threshold could increase. A final, there might be others, is that it could move from perhaps not an electronic expectation to an electronic or more structured expectation. So we have room to move within that framework. In some cases, they said we think it will be electronic in stage three and we could say well, we think we're ready in stage two. So as we think about our degrees of freedom, I think it's good to think about core menu set thresholds and what the mode is in which the measure is being accomplished.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great, thank you. This slide just provides you a little bit with a mapping of what Claudia was just describing. We're going to be going into the details of each one of these, so I'm not going to walk us through line by line here. But I think just to give you an overall map of how the different existing stage one objectives translate into stage two and then—oops, I think we're missing a slide from the presentation. Then in your paper package, there is a listing of proposed new objectives, so objectives that really don't have any link to stage one. We have those as well laid out in individual slides that we're going to go through now.

Why don't we jump right to the first one? All right, there are our missing slides. So why don't we dive into stage one, sorry, for our first objective which is related to lab results. What David and I are going to do is trade off, so I'm going to take the first one here and talk a little bit about the lab report, the lab results one, and orient us to the format that we're going to be using as well. For each one of these, what Kory has very helpfully done is pulled out from the meaningful use recommendations the stage one final rule. So what was it, in this case incorporating lab results as structured data for 40% of your labs; what the proposed stage two is, in this case moving the current measure to the core, so you may recall for stage one it's a menu set item, but with the caveat only where results are available. Then finally in the proposed stage three is 90% of lab results are stored as structured data in EHR and are reconciled with structured lab orders, where results and structured orders are available.

That's what we're dealing with in terms of a recommendation. The issues to consider, and again, these are just framing questions for us and should in no way limit anyone's thoughts on this, is the first question about the infrastructure itself, in terms of infrastructure and process, it's not just infrastructure. Is the infrastructure ready? The readiness of small, independent labs is certainly a question, including critical access hospitals. I think it's an important point for us to recognize that people may have different data or better data, but I think that the data that we've seen from the California Healthcare Foundation and others who have done work on this, is that nationally 75% of labs roughly come from hospitals. That it's only 25% roughly of lab result delivery that happens through the national lab systems. So this is really a pretty important question for us to deal with in terms of hospital by hospital capabilities, particularly as you go down into the community hospital, critical access hospital areas.

Another question is the possibility of the use of direct LOINC transaction value sets to ease implementation burden, HIE capacity in general is another consideration as we think about the infrastructure. A question for us, I think it was one of the more pointed questions that came up actually about a year ago or a year and a half ago when we were thinking about, you may recall our first take of the lab results question, which led to the letter that went out—the CLIA letter that went out—that clarified a whole bunch of things. So we had initial success I think with our recommendations with that. But a question that came up at the time and that I think it's important for us to revisit here, is does it make sense for a meaningful use requirement on hospitals to be that they send lab results electronically and according to the standards that the vendors are certified to receive them in? You may recall that that was something that wasn't put in as a meaningful use requirement on hospitals, but to the extent that we've got these caveats all over the place of where results are available and noting that 75% of results actually come from hospitals and that we have a lever over hospitals with respect to meaningful use, all of those

things could suggest coming together to say that that would be an appropriate meaningful use requirement on hospitals.

Then finally, I think that also begs the question how do we define where results are available, to the extent that that's going to be a caveat that we probably need to keep in place, I would think. But again that's all of our considerations here. Let me first just throw it open and get peoples' general thoughts about this. Dave?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin
Two questions; one, I've never been clear on how easily accomplished the translation process is from some arcane lab information system to LOINC and therefore more easily translated, and maybe somebody can enlighten me about that. The other thing I seem to remember from our discussion around labs and contracting was that their contract terms, maybe it wasn't here, but often the contracts that hospitals have with their vendors will have in there a requirement that they meet any imposed regulatory requirements at a minimal cost. In other words, there's a requirement that the vendor has in there contractually that says we will meet any imposed standard as part of our agreement with you, which might lend, I don't know whether that's true or not, again, these are both anecdotal memories, but the first one, how easy is it to actually accomplish that translation?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm going to actually turn to Peter in a second. My quick answer, having worked with it, is not easy. But the clarifying point I'd like to make before asking Peter to elaborate is that it is not necessary for that translation to happen in order to fulfill any of these requirements, and indeed, in order to improve care at some level. You can deliver results, the certification requirement I think is that the system be able to accept it according to those standards, but that doesn't mean that it has to be delivered that way. And arguably if it's delivered in whatever codification is coming out of the lab, the clinician is benefiting by having it there in an automated way and they can read it and interpret it in the same way that they interpret it in the paper world –

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin
... basically.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Now it doesn't mean that mapping doesn't lay the foundation for higher value, and I'm not suggesting that that is not the case. But let me ask Peter to comment on the difficulty—

Peter DeVault – Epic Systems – Project Manager
We've done this several times with our customers from the EHR side and I agree with Micky that in general it's difficult. Partly, though, it's different every time you do it. So every single hospital lab system has been free during their implementation to come up with their own nomenclature, and they all do come up with their own nomenclature. So to the extent to which it's difficult really varies from site to site. The other thing that makes it difficult is that LOINC isn't uniformly mature. It's pretty mature for general laboratory results, but not so for microbiology and pathology, for example. Now, having said that, I think that because LOINC is fairly mature for a general lab, I think a requirement for hospital systems to report however they're reporting lab results with LOINC codes for general labs might be something that we should look at as a recommendation as a foundation for not just incorporating lab results, but also making them comparable across resulting agencies, which is obviously a goal for data liquidity later on.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Maybe a couple of things, one is that we've got some experience on the hospital side for the translation piece and we've found that it's about $3,000 to $5,000 just to do a white mapping exercise for the most common tests, not the whole dictionary. Then as Peter suggested as well, there's an ongoing cost to continually upgrade and update the lab dictionary. So there's an ongoing cost to that as well.

To one of your points about the hospital being required to use standards and deliver them in the statute format, if there's no real lever for the labs when they're upgrading systems and procuring ... or electronic

health records. Then they will be putting the requirements of having a mechanism for delivering structured data into their procurement and we won't be moving the needle nearly as quickly as if we actually had that lever over the hospital. So it would make, I think, a lot of sense to try to add that requirement just so that as hospitals are making their system upgrade they are requiring ... vendors and perhaps as well the analog machine vendors to actually incorporate things like white coding of the value of the test. And even having some of the interface capabilities to deliver structured lab results using ....

Paul Egerman – Software Entrepreneur
Micky, I was going to agree with what I think I heard Jonah say. My recollection of the hearing we did on this indicated that there was a subset of lab results, there were maybe 100 or 200 lab results that would represent for most organizations 90% of their lab orders. The fact that we already had this in stage one of the final rule says that we signaled to the labs already that this is going to happen. So I don't view this translation as a particularly difficult obstacle going forward with what is being suggested here.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'll try to bring up related things more just to project forward to our conversations this summer. One of the initiatives that is being taken forward by Doug and Arien and the Standards and Interoperability kind of framework, these very focused, open discussions about what additional specs are needed in this space, is they're focused right now on ambulatory lab. One of the questions, indeed, it goes straight to Paul's point of what a value set would look like for lab orders that were to produce the variability, and one of the issues you mentioned is the variable maturity. But there's also the issue of just so many codes that are used not uniformly and it just makes the mapping a lot more difficult. So I guess I would ask a question back to the group. I'm hearing a fair amount of support for the idea of requiring hospitals to report structured labs. Would you want, and I know this moves into the standards discussion, but would you think we'd be ready to require that that be LOINC coded, so hospitals reporting labs and that they be LOINC coded when they report them?

M
Yes.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So you were saying not the microbiology?

M
Correct. I think if we take the 100 or so labs that have been discussed, that would be appropriate.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Just as a point of clarification, I think as we discussed this last year when we were going through this with the Standards Committee, which Amy Ferguson, who is on the Standards Committee side dealing with this, my understanding at the time. We can check back on this, was that the National Library of Medicine was actually building a LOINC subset of the most frequently ordered labs. I forget what they called it, there was a term ... were using for that, but I believe that they were doing that and the idea would be to make it a nationally available code set.

M
Was that the eLinks project?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It's not eLinks; eLinks is California. It was something different.

Paul Egerman – Software Entrepreneur
Micky, to me the right way to do this is the Standards Committee can just put it in the implementation guide for whatever the interface is as to what is the minimum set that needs to be LOINC coded.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

James Daniels – Medical College of Wisconsin – Associate Director
I think it would be important to consider how the crossover is with the public health reporting, because for public health reporting they are actually required to report both LOINC and regulations and SNOMED and the implementation guide. I know you said microbiology is difficult and we shouldn't include that, but they are reporting a lot of microbiology results to public health and they're already required to do that if they choose that as a menu set.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, Deven and then Jim Golden.

Deven McGraw – Center for Democracy & Technology – Director
I'm trying to recall whether the Policy Committee actually accepted this recommendation. I remember us being strongly supportive of it, but it's amazing how quickly the memory fades. I actually don't know that we got the Policy Committee to endorse it. My other recollection of some of the pushback is that the hospital lab information systems are not necessarily part of their certified EHR technology, which means the mandate that comes through meaningful use is not of a certified EHR, doesn't necessarily support the upgrade of the LIS in order to perform this particular requirement. So I would think we'd want to get some more information on that before we would—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, we did have that discussion, you're right. So we have to dig down into that. Jim?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I could have said this probably before we started any of these, but I think on the question that was asked about is it the right objective, I think one of the things that we're seeing in our state. I think it's true in other states, is that sometimes it's not as much the technology, it's the people and it's the providers and getting them wanting to exchange information and to see value for exchanging information. So in thinking about any of these, one of the things that I'm trying to think about is for the amount of effort and work that it is, is this something that individual healthcare providers are really going to seek out as they're treating their patients? Is this something that's going to be of great value to them, that's going to facilitate greater exchange?

So I guess one of the questions that I don't have the answer to, but that I would be interested in, either from providers or as we seek out more information, is the recommendation we got from our community was that in fact we should have more clarity around the LOINC standards and some of the reference stuff that is in there. And my question is, if we were to do that with these recommendations, would that encourage providers to seek out this information and try to do exchange more? Because it seems to me the amount of effort and cost and work that goes into it needs to be related to, is it going to encourage providers to exchange, and so that would be something that I would specifically be interested in. I know that the LOINC issue in particular, that has been something that our provider ... real requirement to clarify up those issues around this, and if it helps to facilitate exchange I think that makes sense.
With regard to the hospital piece, I get Deven's challenges, but we talk a lot about using policy levers, that one seems to be a reasonably clear lever to me. But I do think it will cause the hospitals a fair amount of pain, so we're likely to hear from them.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Let's see, I think we've got Walter and then Steve Stack.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
A couple of comments on this one. First of all, this is only for EP on stage one, this is not for hospitals, so this is not a measure that applies to hospitals in stage one. I'm not sure if the intent, I'm looking at the stage two but it doesn't look like the intent is to also make it on stage two applicable to hospitals, but it will still be an EP only measure. That's one point of clarification, I think.

The second point that I want to make is this is not requiring us, I think Deven mentioned and others, this is not requiring the labs to do it. This is requiring providers to receive it when it comes electronically and that more importantly, as more of the workflow asset is received is incorporating that data into structured data even manually. So that means that you could receive the data on paper from a lab and then have to code it manually internally, a structured element into your EHR. So what this is doing is really moving that stage one from a menu into the core and maintaining the same requirements. The requirements are more extensive than just purely receiving it. It talks about incorporating it and then in the third stage integrating it with the lab structure order going out from the provider. But again this is EP only, not hospitals.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Let's go to Steve Stack and then I'd just like to pause and have us group around where the conversation seems to be and see if we can get at least some quick consensus on it and move to the next—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Walter, I'm glad you commented on that about receiving the data. I think it's really important that we do focus on the high yield things, the 100 or 200 things, and concrete clinical examples of this. Across the universe of physicians most of us, in one sense or another, would know how to interpret a complete blood count or basic metabolic profile or a test that said you had a heart attack or you didn't. Those would be common labs we'd be familiar with, and those are things used so frequently that it should be possible to standardize that across the universe of healthcare. But I think one of the things that we touch upon a lot more than we realize in these settings is there is a morass of other things that are done all over the place in very specific niche little areas that are important to the patients who see those providers of care, but are not of universal importance across the entire spectrum of clinicians. So if I sent someone to a rheumatologist and I need an opinion, they may order a whole slew of arcane tests with which I am utterly unfamiliar, have no desire to ever become familiar with, and all I really want back from the rheumatologist is a paragraph that says we've evaluated your patient and this is our impression.

So to try to standardize all of those labs is a task that I think is way beyond where we are and where we really need to be, quite frankly. We need the interpretation of that from the professional. So I think we should focus on that core set that are universally applicable, and that may touch into microbiology, Chlamydia or gonorrhea, yes or no, it's positive, it's not. So I think we should be very explicit, and I don't know who does that, the Policy Committee, the Standards Committee, but I think it would help all the players if someone actually determined these are the things that are going to be standardized and required.

Then the other thing is I think we need to be careful when we set the thresholds. Because I think what we're finding is I hear more comments from specific providers that there are clinical situations that happen all the time that we don't really think about or are aware of, like a retina specialist who injects the eye with medicines but doesn't prescribe medications, but will fall into the inclusion criteria for a certain part of meaningful use but have no meaningful way to satisfy the requirements unless they prescribe everyone Naprosyn that they don't need just so they cannot get a penalty. I think we have to be careful how high we set the thresholds or include exclusions even for these labs so that doctors' offices don't have to sit and manually enter a bunch of information just to comply with something that's not helping and so we don't penalize people for not doing irrational things.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Go ahead, Doug, and then David Lansky. Then we're going to try to wrap up this discussion.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Sure. This has been a very good conversation, and I just wanted to update people a little bit on what's going on in the Standards and Interoperability initiative around lab and just give you a couple of thoughts about what we're trying to do there. One thing is that we have to look ahead to the proposed stage three objectives that we have, and there are three things that are going to overlap that make it important to begin structuring the kind of data that we may anticipate for stage three.

As we think about quality measures, as we think about decision support and we think about public health reporting, I think it becomes increasingly important to try to figure out well, what is the low hanging fruit, what are the important things that we need to get structured that allow those kinds of things to be enabled. I really like the comments around trying to determine what is a scalable set that we can look for, because it is expensive to do lots and lots of mappings, but if we can get a manageable set that everybody recognizes and uses I think that's going to be very helpful. So within the S&I framework we've actually been encouraged to see lots of participants coming together that include not only the providers and the hospitals and states and whatnot, but also to have some of the big laboratory vendors coming to the table as well and taking a look at this.

So I would put a plug, we hope that we should have some early recommendations within the course of the next couple of months, and certainly in time as we think through meaningful use stage two. So I'll be hopeful that we can provide some feedback to this group as the participants of the S&I initiative around lab do their work.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you, Doug. David?

David Lansky – Pacific Business Group on Health – President & CEO
My comment, I guess, goes to Walter's and Doug's too. Given our overall purpose, back to your opening comment, Micky, if a large proportion of the relevant lab data is coming from hospital labs now that may not be conformant to whatever we're looking for. We don't have a requirement in here to eligible hospitals to direct their attention to the export outbound messages that are conformant, maybe we need to really actively recommend there be an additional objective to the Meaningful Use Committee that addresses these last couple comments and maybe goes to the set of core items that Peter teed up. I don't know whether it's our job to frame that objective, or just recommend that they do so, but it seems like if we want an ecosystem that functions over the longer term we've got to really put equal pressure on both the outbound and the inbound side to this.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Do you have a quick comment, Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, actually I'm going to correct myself. This measure does apply to both eligible providers and eligible hospitals. It does not apply to the hospital lab.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, exactly. Yes. Okay, great. Well, thank you. Just launching now from David's point, it seems like there's a fair degree of consensus. Let me just ask, everyone can speak to this issue, but the question of whether this ought to be something that is a hospital meaningful use requirement, with the caveat that Deven pointed out, that we did dive into this. There were some technical issues that we needed to resolve around how the policy levers would actually have to work in this context, and also recognizing that we need to understand probably a little bit more about how would we define those commonly used tests and all of that. But it seems like there's a fair degree of consensus around the table that we want to be able to add as an additional objective this meaningful use requirement on the hospital. Is that a fair conclusion?

In terms of the objective that's here, how do we feel about moving this current measure to the core with this caveat of only where results are available? So first off, maybe we should take that in two parts. Are we comfortable with moving it to the core?

M
Yes.

M
Yes.

M
To Steven's point, maybe it's where available or applicable, because of the lab – well, you were actually talking about the other ....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
One other question here then is moving it to the core doesn't do anything about changing the measure, so it's 40% now, so we've got a two stage question. Are we comfortable with moving it to the core? It sounds like we are. The second question is, does 40% seem like the right number?

M
Can we read the proposed rule to say move current measure to core, but only where 40% of results are available as structured data?

M
Electronically.

M
Electronically? I didn't realize that it was electronic.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I hoped Allen Traylor would be here to be our MU. Is he here? Excellent. I thought you were incorporating 40% of those you receive structured. It's not 40% of all labs. Allen is our MU expert for the day, stage one, Allen, is that right?

Allen Traylor – ONC – Meaningful Use Policy Analyst
Yes, that is correct . It is ....

Claudia Williams – ONC – Acting Director, Office State & Community Programs
It's also if you receive structures, that you have to incorporate 40%.

Allen Traylor – ONC – Meaningful Use Policy Analyst
Right, and it doesn't have to be electronic—

M
... on whose records are maintained within the EHR.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Right.

Allen Traylor – ONC – Meaningful Use Policy Analyst
And it doesn't have to be electronic. To Walter's point, you could get it all on paper and type them all in as long as you did 40% of them.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... said 40% of all clinical lab results ordered by the organization whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. That's the actual quote from the regulations. So it is not electronic.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Let me ask this, if the hospital objective recommendation that we have were to be introduced, do we think that we still need it to be at 40%, or could we say, could you introduce that 40% maybe higher is achievable. Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't know. Since this is information exchange, I'm hoping what we're trying to achieve is that some provider of a lab service sends you information and you incorporate that information electronically into your EMR. The reason I'm saying this is I'm hoping what we don't intend to foster is having to have providers sit in their office and key in all of this data. I like the electronic addenda there about what's received electronically, and then the 40% or not, it's irrelevant almost. It's whatever comes into your EMR in a structured format should automatically be incorporated into, it should be 100% at that point whatever comes in structured.

M
Forty percent was there because we had no lever on the hospital lab systems and I'm hoping we'll actually come back to talk about what those policy levers might be.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Part of it is really a lot of the information received from labs on standard paper then just gets scanned and saved, but it's unstructured data, basically a screen shot of the paper, so that when a doctor is looking at the record they can pull it up as a PDF screen, not structured. So the concept of still forcing the conversion of that screen shot that is now saved electronically on the electronic health record but is unstructured data, converting it into structured data so that then it can be more actively analyzed and CDS clinical decisions for systems complying to it, is still good. I think the goal of converting data into structured data still is important in this process. I think it's two thresholds. One is if you're receiving already electronically the lab results on structured data, 100% should now be incorporated electronically in a structured format into your EHR, so that's one path. Then for unstructured data that you receive, then at least 40% you have to convert to structured data. Those are the two separations that we need to make.

M
Actually, is there one more separation there, because we've been talking about the 100 or 200 labs and not all labs, so should we say that 100% of the labs that are in this set, once that's decided on, if they're available electronically should be incorporated electronically into the EHR?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
In a structured format, combine electronic and structured.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That was only for vocabulary mapping. Just because it isn't mapped to the vocabulary doesn't mean that you can't receive it as structured data.

M
Yes, but ... interface.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Excuse me?

M
It will error out in the interface, or you have to map your EHR to whatever that hospital system is sending to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, but I would think you would always still need to be able to do that, because you need to be able to get those results. So you need to get those as presented. We haven't solved all the problems. Walter,

one thing, it seems to me that it's a higher bar actually and a more difficult one to say that of the ones that you're not getting electronic, 40% have to be structured. The 40%—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That's the ... today for the ....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, for today it's 40% however it happens, and the assumption was that that provides a strong incentive for people to get as much electronic as they can, and if they can get electronic to cover 40%, then great. Do you see what I'm saying? If you say that it's 40% of whatever you get not electronically, you have to put a structure. Now you're saying that they have to type, even if they get 10% they have to type in the 4% out of the 10% that they are not getting electronically, which is something that may be out of their control.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm confused with the 40 and the 10. Today it's 40% of all the lab results that I receive either in a positive/negative or numerical format then have to be entered into the electronic health record and structured data format. That's it today, 40% of all the lab results that I receive, whether they're electronic or non-electronic.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, so we're comfortable with moving into core, it sounds like we're at least comfortable with keeping it at 40%, but is there any appetite for saying that it ought to be higher or justification that it ought to be higher, either connected to the hospital objective or saying that maybe 40% ought to be electronic? That would be another way. I'm sorry. Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
... that you capture this element or how we make our recommendation about. The other thing is if it doesn't come in electronically, so if we don't have standards that have been agreed upon, then if someone had to key it in then there's a real problem, because they're putting a number in that's not in a standardized manner and so it doesn't really support the clinical decision support and stuff. Because if someone has to key in a number and then the units and nanograms per ml and things like that, now you've got structured but perhaps nonsensical data that doesn't support anything. I think we really have to focus on the entire ecosystem moving to a core set of things that are standardized across everywhere that it's used or else it doesn't support anything, except a lot of work for someone sitting at a computer typing in nonsensical data.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, but you're not suggesting going backward?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
No, just being very specific. Really what you want is whatever's created at the lab provider, certain things in structured data format that is standardized across users and then is shared electronically, and then when it comes in electronically it's incorporated electronically so that then it supports these other decision functions and things that we want to have the support.

Paul Egerman – Software Entrepreneur
I hear what Steve's saying about it comes in electronically, and I just have a question. Aren't there some tests or starting to be a growing number of tests that are performed in the office, that you would enter those manually?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure, unless you had an interface set up with your in office system; small practices won't, larger practices will. Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs

I'm just thinking, what this conversation is really pointing to, and I think we should put as strong a point on it as we can, is that the doc is receiving the readiness of the other players, and the way in which we can move that along more rapidly, if there's a way to do it it's through the hospital. That's what we've been saying. But I think that just explaining the importance of that for supporting not just as a hospital requirement but supporting all the folks who are consumers of that information is really critical.

The other thing I would say as we started parsing out different ways to think about this is 100% electronic, 40%, one of the things I think we struggled with in stage one is how to keep measures simple and not create a lot of reporting burden for docs that was unnecessary. I don't think we're recommending that there be a parsing of the measure into one part electronic and another part around everything, but we just need to be thinking about that for all measures. That it's tempting to come up with a more titrated measure that's a little more complicated, to get to exactly what you want, but we're bumping up against the other goal, which is to keep it clear and reportable and not have a big burden of reporting for the folks who are the meaningful users.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
One quick comment on the word "electronic"—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
The last comment on this, we've got to move.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, very quick. It's very important to distinguish electronic from structured. In other words, a screen shot of the lab result is sent electronically but it's just a PDF of that paper; that's electronic but that's not structured. If the lab sends the results on a LOINC based message in which the number for a particular result is actually coded, that is an electronic plus structure. That is an important distinction because the point is we can still receive lab results on a PDF format and consider those electronic, and that's not the intent, I think.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, we want discrete data.

W
....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure. Well, yes, I'm getting a little concerned about time. But the question is where available and how we would deal with that, recognizing that the problem for an eligible professional is that some of the stuff is just out of their control sometimes. Often they are required to use certain labs and particularly with respect to hospitals they are slaves to whatever the hospital schedule is, really its interfaces.

M
Micky, is "where available" our wording or is that the—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's their version. That's within the recommendations.

M
That was in the rule?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It's in the recommendations that went out for public comment from the Meaningful Use Workgroup.

M
I'm assuming it's there for a reason.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... do we have any recommendations on defining that? That could be interpreted in a lot of different ways. Is it one lab? Is it most of your labs, more than 50%, the suppliers that provide more than 50%?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... I think this applies to where it says "where results are available" it means that there are some eligible providers that do not request lab. By not including that where results are available, then those EPs might not be eligible to or might not be able to meet this because they never ordered labs, but it still says I have to receive labs. Those provisions where it says, "but only where results are available" in some cases it's my understanding that it refers to for providers that do order labs, because again there are some that don't.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I don't think so, because if you didn't order it wouldn't apply, because it's 40% of whatever you have. And it seems to me that that was probably a caveat put in there because they moved it to core now so there's no way the provider can get away from it. But recognizing that if you're in an environment where all the labs who you send patients to don't have anything, it's going to be pretty hard for you to get to 40% unless you're literally typing in 40%.

Paul Egerman – Software Entrepreneur
I'm taking a guess that it means that you maybe are in an area where maybe overlap from, say, a community hospital and a hospital doesn't get the information electronically, they just fax you the material, so if all of your labs are received with faxes it becomes hard to manually enter it. That's just a guess. I don't know.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. It was addressing your point, Steve, that we don't want to force them to type in 40%.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right, and I know you need to move us on, but one other complexity here—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Another complexity?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
We haven't even touched on this, so this is something that as a user of the labs, so if I use a test called a D-dimer to screen if you have thromboembolic disease, so a blood clot in your lung or your leg, I can't just order that test. I have to know what type of assay the lab is using. The results that they report are widely different because maybe normal is less than 1 at one hospital or less than 10 at another or less than 50 at another, it depends what assay they're using. And even if 10 hospitals are using the same assay, they have to standardize on their local machines based on temperature, humidity, and all sorts of other stuff, so their normal range is different than every other hospital's normal range. The reason I'm sharing this complexity is, I know we want everything to be standardized data, but the reality is it's really very not standard.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So it's very ... result.

M
... CLIA reporting requirements and part of the structure of the structured data—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Well, yes, but in my hospital for that D-dimer test, as a matter of fact we just went through this because our Cerner EMR, there's rigid fields on what they can and can't put anywhere. In order to get the interpretive guidance that you need to interpret the test properly we've had to force that the result's not even printed in the result field anymore, that it says "See note," "See note," and "See note," and you have to click down three tabs until you get to a screen where the interpretive guidance is presented. Then the results underneath it, because we had a concern people were using the information inappropriately. So sometimes you need the data in its glorious, unstructured format because you need all the text that goes with it to even know how to interpret it. I'm not saying this to throw more of a wrench in the thing. I just think it's really complex. The desire to have structured data and share it so that computers can help us is very laudable. I think it's far more complex at the actual use at the patient bedside than perhaps we sometimes—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And maybe we can address that as we think about what we're seeing with respect to a requirement on a hospital's restructuring—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think that as the meaningful use folks look at it and stuff that they need to have some of these clinical scenarios—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. In terms of process, I think what we want to do is we'll capture what we think is consensus here, provide it back to everyone as a following up on this meeting, and then we'll have, I'm sure, a very vigorous conversation over the phone and on e-mail about the details of this. I'm going to move us forward actually. David actually has negative ten minutes to cover the next topic.

David Lansky – Pacific Business Group on Health – President & CEO
No problem. We're now moving on to the summary of care record. This initially, as I recall, doesn't require it to be electronic. The goal is to get the right information into the hands of the receiving provider and it's associated with transitions in care and referrals. I don't know if any of you have experience with this, how it's going and what people are experiencing and how this will be assessed by CMS, the denominator and numerator. Allen, do you know any more about how that's actually going to be implemented?

Allen Traylor – ONC – Meaningful Use Policy Analyst
Yes. I think the idea is to try to be able to track electronically, as opposed to the paper moving forward. Some of the results that we've seen so far in the last couple of weeks with it from the RC is that a clearer definition needs to be made here on what is the transition of care record, what is included in it, and then how is it transferred. People want to know exactly how to do it. They don't want the ambiguity of can it be given to the patient and the patient take it to the next provider of care.

David Lansky – Pacific Business Group on Health – President & CEO
The providers are requesting guidance on the transmittal form?

Allen Traylor – ONC – Meaningful Use Policy Analyst
Yes, from what we've seen.

David Lansky – Pacific Business Group on Health – President & CEO
So now at stage three we're talking about making this electronic, which would solve that problem. Potentially we would have one pathway to provide the specifications for it. We're in the middle of the transitional process here from articulating even a paper recommendation to ultimately an electronic recommendation. So the questions we pose here for our consideration is do we accelerate the transition to electronic requirements, to make that a stage two requirement, and we should just talk about the infrastructure that's out there today and whether we can expect there to be sufficient infrastructure to facilitate the electronic transfer in a timely way. Let's start with, as Micky did, the simplest question, which

is do we move as it says in yellow here, do we try to move the existing stage one requirement to core and make it a universal expectation? Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
.... So have we defined transition in care?

Allen Traylor – ONC – Meaningful Use Policy Analyst
Yes, we have .... It's from one provider of care to another. A transition of care has to be from a provider of care to another provider of care.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Okay, so it's not like someone comes in for an ambulatory visit, because I'm sending you from the hospital to a rehab facility.

W
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It's across legal entities.

M
Yes, you can't ... the provider in the office next door in the same practice with two providers. It has to be setting provider, setting of care.

M
It's not, let's say, within a hospital from department to department, that's not included in this.

M
The reason I say that is—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Usually that's part of the same ... of record. That's not an exchange, really, of data. Here are really two separate electronic health records exchanging data, and it could be one provider referring to another provider, a provider to a hospital, a hospital to a nursing home, those kinds of things.

David Lansky – Pacific Business Group on Health – President & CEO
... caveat, it's not two electronic health records exchanging data. It's one exporting the patient and the patient's data. It could be sending out a printed—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Good point. Yes, sending it out.

David Lansky – Pacific Business Group on Health – President & CEO
... to the patient and saying good luck.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here are some concrete examples. If we have someone in a hospital for a week with pneumonia and we have to send them to a rehab hospital that is a very clear transition of care. Absolutely we should have a transition record for that. If I have out of 100 people in a day 10 come in with broken bones and I splint them and send them out from an emergency department and I say here's the name of the doctor who's on call, you can call there or you can use anyone you choose to, which is what ends up happening. They sometimes call their primary care doctor the next day or find out what their insurance panel will provide for them. For us to send records to the guy who's on call who we know from experience may only see 3 of those 10 materialize at their office, that would be a poor choice to define that as a transition in care.

Now, of course when the patient arrives at an orthopedic specialist to have their definitive fracture care, then if that orthopedic specialist wants those records, then they should be able to get it. So do you see what I'm saying? So you create a real problem if you define every visit with a clinician which could potentially result in a transition of care or is likely to result in a transition but you can't be sure to whom that transition will be to. You can't mandate, of course, but you shouldn't rationally mandate that something be forced to someone just to fulfill a requirement when they may never show up at that provider's office.

David Lansky – Pacific Business Group on Health – President & CEO
Peter?

Peter DeVault – Epic Systems – Project Manager
To Steven's point, there are a few different use cases here. There's, I know where I'm sending my patient and I know where my patient came from, two different things. Maybe we should interpret the provider's summary of care as making it available to those who ask for it, or sending it to those who need it next to accompany those two different kinds of cases.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think what we want to avoid is, I don't know who your PCP is and I never asked you. I think we're trying to build in a proactive expectation where it's clear you have a PCP, you got discharged with pneumonia from the ER, does the PCP need to know that? Absolutely. That is a different scenario than, I have no idea where you're going for your orthopedic visit and I'm trying to guess where I should send this. But I don't think we want to let folks off the hook by changing the requirements such that they never ask ....

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I almost think we need to enumerate the kinds of transitions of care and in that context explain what "provide" means. Because one of the most important cases, well, they're all important, but one of the most important ones is the patient arriving at the emergency department and there's no way that the PCP could have known that they were going to be at the emergency department today. But ideally the PCP's EHR system would be available to respond to a query from the ER and provide that summary of care. I do think we probably need to enumerate the types of transitions if we're going to make this a core requirement and be explicit about what we mean.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... defines basically who transitions, this applies to EP or if a hospital transitions or refers their patients to another setting or care, or provider of care, and then provides a summary. Then this has two connotations, it electronically receives the data or it electronically transmits the data. The question, I think, Steve, that you have is can I transmit the data without yet knowing who the provider is going to be that is going to see that patient in the future, or in a referral situation, or should I wait until the provider submits a request for that data so that I can transmit the data. Because in some instances you've got to establish a patient relationship before you can disclose data to another provider.

Peter DeVault – Epic Systems – Project Manager
... the intent here from the wording of the rule, Allen, maybe you would know better, is that the referring provider is making an active decision to transition or refer to a known party. It's not this open ended, I don't know where they're going. There may be many such use cases, but this rule as originally drafted I don't think is meant to address—

M
Yes, and this rule really applies to the provider who is initiating the transition. It doesn't apply to the receiving—

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't think there's a big, I should be careful there, but my interpretation here is that moving it to core is not the fundamental issue or problem, because we want to encourage this. But I think the specific instances in which we are encouraging it, like right now, is important. Because if I send you to a nursing

home or I send you to a specialist, I know discretely where you're going and what we intend for you to achieve there, and that should be done. People identify physicians as their doctors regularly and in fact they haven't seen that physician in five years, and we call the doctor and they say that they're not even an active patient with me anymore, because they're young and healthy and they haven't needed to see him. The amount of false information provided by human beings, and I'm not picking on patients or doctors, but just human beings, is astounding.

So we shouldn't mandate for every setting, and there are 120 million, and I know my setting best than the others, 120 million emergency department visits a year. The amount of churn we could create by mandating pushing of information places where it will not have any value is substantial. I think there are clear high yield transition points that happen with regularity for people who are acutely sick and where that information absolutely should be expected to be pushed. So I think we have to spend some time on defining where those are. But moving into core I don't think is a problem and keeping the threshold at a level that's attainable for stage two I think is also important.

David Lansky – Pacific Business Group on Health – President & CEO
Let me bring it back to our charge, which isn't to re-do the work of the Meaningful Use Committee, but to think about the information exchange requirements to support this objective and whether we have concerns about the proposals for two and three as they pertain to IE requirements. I'm wondering, and we haven't talked yet about the issues of provider directories and Direct and so on, if that is the facilitation of achieving this goal. The other thing to think about from a quality measures point of view, whatever the threshold is, it's more important to us, I think here to say do the providers in the program have the capability of doing this. There are other mechanisms to pull, incentivize, motivate people to actually do it or not, depending on the context. Our job, I think, is to think primarily about the facilitating capabilities of the infrastructure. Do you have more, Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think my comment with regard to stage two and moving into core isn't my concern. I think my concern is the fact that it doesn't need to move electronically, in that I think the rule lists a variety of ways, including on paper, and as someone who's responsible for trying to get a state HIE developed, that's not helpful. I don't know how to say that any more clearly. The threshold could be lowered and have this required to move electronically via Direct or state HIEs. I'm not suggesting how it needs to move electronically, but if you want to get electronic exchange you need to move this off of paper.

David Lansky – Pacific Business Group on Health – President & CEO
Micky wants to get in, and then Claudia.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
My only comment as it relates to, David, your valid point that we're asking the question of whether the HIT/HIE infrastructure is sufficient to support what it is we're trying to accomplish. Building on Steven's point I think it is very important to define what transitions of care mean, because as we move to the ability to electronically measure this, that's going to be very, very important. How do you actually identify within the electronic health record system that something is going to be a part of this denominator for transition of care. Is it something that you designate as a referral? But anyway, I think that that's an important point of it as well.

M
....

David Lansky – Pacific Business Group on Health – President & CEO
I'm sorry, what's that?

M
Just briefly, I think this goes back again to the data integrity issues because the infrastructure that we typically call upon to sort these out are the provider directories, the EMPIs, validating the provider to

patient relationships, so again I think that's appropriate for the proposed stage three. And I'm not sure if there's a subset that we could carve out for electronic in stage two.

David Lansky – Pacific Business Group on Health – President & CEO
So let me clarify ..., you don't feel that we're prepared to move the electronic transfer to stage two?

M
I think there's probably a portion of it, but I'm not quite sure what that would be. But I think in order to get a critical mass of having these records available we have to have that underlying infrastructure. Whether that's a query-able system, I like where you guys are going where you have a central registry or something like that, but without those infrastructures I just don't think we can meet them in the time frame from a provider organization.

David Lansky – Pacific Business Group on Health – President & CEO
I think in the sequence I've got Walter, Claudia and Peter.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Just a quick question. I thought this was supposed to be electronic exchange, so provide summary of care records, 50% electronically, and we had a standard and the standard defined in standards rule.

David Lansky – Pacific Business Group on Health – President & CEO
... literally printed off and—

M
....

David Lansky – Pacific Business Group on Health – President & CEO
Right. Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think you raise really good points, Sid, but if we just try to parse this, if we're trying to, I'm taking a direct analogy, so today to meet this requirement I need to know who you are, I need to know that this is the doc of my patient and I asked and they said so. I either get the phone number from the patient or I look somewhere else and find it, know that they're in the hospital, and then I call the front desk person and fax it over. I'm not sure we need to make it any more complex than that for this stage of electronic, in the sense that there might be ways to discover. We would love for directories to support that in a very easy way, but I think similar to the basic direct constructs we're going to have ways to discover it that aren't completely reliant on directories. That's just one thing.

I think the other thing, just maybe one more meme on Direct, that some of the kinds of offerings we're seeing in the market which could support this would be certainly the great HIE efforts, including those that are trying to establish HIST and stuff. But also, for instance, a large national provider organization has teamed up with a vendor to offer $15 a month direct messaging service to anyone who wants it. That's not to say everyone will have such a thing or we think everyone should have such a thing, it's just questioning if such products are available and HIE efforts are making big progress. We're starting to see, that would not be built into the EHR, that would be probably more of a Web mail type service you would use, attach the CCD from your system and send it over securely using the Direct protocols.

So that's something to keep in mind, to the extent that such offerings are available and easily usable, you still have to question, though, if you're trying to send to a ... like to a nursing home we have some mechanisms but not many to get them to be the recipient of this. So is it that we're sending electronically but if the other person can't receive it? So I think that even if we believe that the senders, the docs, and the hospitals could probably easily send it, there are still questions about whether it can be pretty ubiquitously received. Or do you have a little template that turns it into a fax? There are ways that you can accommodate that, but I think we have to think it through.

David Lansky – Pacific Business Group on Health – President & CEO
Peter and then back to James.

Peter DeVault – Epic Systems – Project Manager
If it's true, and it sounds like it is, that this requirement only addresses referral type scenarios, then is it also true that we don't have a meaningful use objective for the emergency case type use case?

W
....

Peter DeVault – Epic Systems – Project Manager
Not discharge, but admission, so when the patient shows up at the emergency department being able to get a care summary?

Paul Egerman – Software Entrepreneur
This is Paul. Can you put me in the queue, David?

David Lansky – Pacific Business Group on Health – President & CEO
Sure, Paul. Just after James, I think. Unless, Peter, you ....

Peter DeVault – Epic Systems – Project Manager
I think we're missing a major opportunity to improve care if we don't address it in meaningful use, it was news to me that this was only for referrals, but we're missing an opportunity to improve care if we don't address the emergency department case.

David Lansky – Pacific Business Group on Health – President & CEO
So potentially we could talk about a pull requirement that had the capabilities there that meaningful users can provide upon request an electronic summary record.

M
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Have you .....

Deven McGraw – Center for Democracy & Technology – Director
We don't have any policy infrastructure yet for pull transactions. I think that the PCAST Report actually highlighted that pretty starkly, at least for me. And it's on deck for tiger team work, but we don't have it.

David Lansky – Pacific Business Group on Health – President & CEO
So we can capture that and relay it back to the committee?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Let me get back on the program. James, and then Paul.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
... build on something that Claudia said. In thinking about the denominator you have not only what counts as a referral, but I think one of the things our providers are concerned about, they're concerned about it now at stage three, but if you made it electronic in stage two the question is how do you actually calculate the denominator? Because if I'm supposed to send it electronically and I can't, because you can't receive it, how do I keep track of that and how do I monitor that? So the question really is, how do I verify that I'm hitting my threshold because I can't really control what you're able to receive? And that's been a concern that we've had.

David Lansky – Pacific Business Group on Health – President & CEO
Paul?

Paul Egerman – Software Entrepreneur
Two comments; one is, I understand this objective right now, it's entirely around paper. So it seems to me that we're only interested in it if we want to add an electronic requirement to it. So that's just one comment. The second comment that I have relates to the emergency department situation and also Deven's comment about PCAST and what you call pull transactions. The PCAST Workgroup taskforce came up with a proposal for meaningful use stage two that's going to be considered on Thursday that's specifically for the emergency department to do a query response under some circumstances. With the idea being that if it's limited to the emergency department perhaps you can get some of the policy work done in advance of stage two of the meaningful use.

David Lansky – Pacific Business Group on Health – President & CEO
All right, I think we've made the rounds. Let's see if we can come up with our suggestions going forward. Back to the minimal questions we were first given, should we support the movement of this to core, as opposed to remaining a menu item? I haven't heard any dissent from that, but given Paul's last comment it's still in a paper, not necessarily electronic world.

The second question is, when is it appropriate to request that to be an electronic transfer? We heard some support for doing that even if it means lowering the threshold but getting there to be electronic transfer more generally expected and will stimulate the other infrastructures that we care about. ... about ... that notion, so there's support for moving it to stage two and perhaps reconsidering what the threshold is. Peter?

Peter DeVault – Epic Systems – Project Manager
... for us to be able to do that. I do think, though, that if we're talking about the push case itself, that there isn't the infrastructure today for stage two to support that.

M
I was hearing ... Claudia the hypothesis that if we soften our expectations ... infrastructure that is, it's an ... point. It could just be a secure message.

Peter DeVault – Epic Systems – Project Manager
I think the infrastructure is in development, but I don't think it exists today to support a meaningful use requirement in stage two.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think one box we should focus on is the next box, proposed stage three, which now says "Summary of care record provided electronically for 80% of transitions." So we're jumping from a stage two that is only narrowly doing a core, moving from base to core from menu to core but still letting things be done on paper mostly, although electronically it's possible too, but it's not required. So I would think that it would be helpful to, if we really think stage two is a stepping stone to stage three, we need to incorporate some sort of an electronic expectation in stage two. So maybe it is moving it to core, saying "x" amount has to be done whether paper or electronically, and then "x" amount has to be done electronically for sure.

Peter DeVault – Epic Systems – Project Manager
Maybe we can create a "where available" type thing like we had in the previous thing.

David Lansky – Pacific Business Group on Health – President & CEO
Dave?

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin
How we handle this in other areas is to demonstrate an ability to, so maybe there's an additional provision in there that would demonstrate in stage two an ability to transmit electronically.

David Lansky – Pacific Business Group on Health – President & CEO
So on the spectrum from an ability to a low threshold, say 10% or something, and Walter said maybe that's a subset of the 50, we've got tiers here of functionality. Where is there any consensus— I've heard consensus that stage two should include something electronic, because otherwise we're not moving to stage three and we're not really achieving our goals. And I've heard the caution that there may not be capability for all providers—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
But if you look at the certification and standards rule, the standards rule that is in place already established standards for that type of exchange specifically and the certification established certification criteria specifically for that exchange. So it's already included in the standards and certification criteria today.

M
That's accurate. There's a standard for the format, the content, but there isn't a transport standard for the exchange itself.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
But the transport may mean many things, method to send it, exchange.

M
That's not part of the certification requirements today.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
No, it's not. But the method for exchanging or for transporting the message is something that can be used in any of the exchanges, not just exchange of summary of record, but lab results or any of the other exchanges—

M
... your comment that it's already specified and required in certification requirements today that you can do the exchange in a certain way.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
No, no, the certification establishes the capability of the EHR to support the standard for the format.

M
To produce and consume.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
To produce and consume, exactly.

David Lansky – Pacific Business Group on Health – President & CEO
So just a clarifying question then, Peter, so for 50% moving in to core you're uncomfortable with 50%, if we say that 50% has to be electronic? I just want to make sure if it was clear. Or were you concerned that it would be 100%?

Peter DeVault – Epic Systems – Project Manager
I'm uncomfortable with that if we don't very carefully craft a where available type clause like we had in a previous—

David Lansky – Pacific Business Group on Health – President & CEO
Okay, because I'm wondering if one out here is to say that electronic means that it is received in a way that can be electronically consumed, that can be consumed by the system, so I could literally take it, put it on a Flash drive, and give it to the other party. But what that would prevent is that I can't print it off and send it to you anymore and I can't fax it to you anymore, and I can't give you a PDF anymore. I would

actually have to give it to you in an electronic form that you consume, but I'm not defining a transport. That could happen over—

M
... because you're adding another layer of stringency to it, which would be good.

David Lansky – Pacific Business Group on Health – President & CEO
If I can print it electronically as a PDF or as a message, is that okay for stage two? We don't have to talk about structured transmission here or receipt here. So where do we want to be on the continuum of rigor is something we need a preliminary sense from this group. We don't have to parse everything today. I'm getting a sense of where we want to be, which is yes, electronic. Your last question, I would personally be okay with the PDF. The transmission is electronic but the structure of the document is unspecified today.

M
Well, I would actually ... because the structure of the document is specified today as either a CCR or CCD and if we're going to do it electronically in some form, and I like the idea of maybe making the form of what we mean by electronic wide open, then I'd say go for the structured—

David Lansky – Pacific Business Group on Health – President & CEO
Really? But that is a consumable to the non-EHR enabled recipient.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... the way they—

David Lansky – Pacific Business Group on Health – President & CEO
Right, the language—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... the writing of the standard—

W
It was both, ...

David Lansky – Pacific Business Group on Health – President & CEO
Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think to the extent that we elevate the rigor we potentially may decrease the utility from the people using this stuff. Because I don't think we really anticipate the—I'll give you an example. We give people these x-ray disks and they can take them with them and put them in a computer, and I'm not looking back to the old days, but the piece of plastic that had the image on it was a universally interoperable thing. You could just hold that x-ray up to any light source and read it. Nowadays you've got a disk, you've got to get it in the computer, make it work, make the reader work, look at it, try to figure out how to operate it. So there's something to be said—paper is incredibly reliable as long as it's not wet or burned, and so I think we should be careful how we elevate the rigor or else we may make things irrationally unusable.

The other thing, I hope we have some way to put in that as something that needs real work is finding which transitions we specifically mean this to apply to. Because I even have hesitation about the ER setting per se. I know we may have pull stuff, but I think that there are a small number of people who are particularly ill who will benefit tremendously from all of this stuff. The 18-year-old who breaks their ankle because they were skiing is going to have a very brief episode of care, get it fixed, and go on with their life. But the one size fits all for all of these isn't going to help them like it's going to help the person with chronic illness who's going major transitions of care. So we should be careful not to make it apply … across everything. So we can't define that ... outside our scope, I think just some observation with our document that that needs to be defined better is probably—

David Lansky – Pacific Business Group on Health – President & CEO
Let's see if we can move on, given all this very helpful discussion. Hopefully we've captured enough of it to relay to the next round of meaningful use process. I don't know that we came to a conclusion of how much structure. I guess we did say that the language, human readable and/or structured, is fine. So we want to, yes, move it to core. We want to make stage two electronic, to some degree. There's a threshold level we haven't solved and there's the focal point issue that Steve raised that we haven't solved, but we can hopefully take those, at least in terms of our objectives, do we have some consensus about the set of steps that will move us to the next level?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
We're talking about two thresholds. The threshold of ... measure and a sub-... for the expected electronic. Because moving it to the core means 50% of all transitions, but we're suggesting adding and 20% should be electronic, or something like that?

W
Or where available. I'm not sure which is easier to implement. But it's acknowledging the variability in ability to receive that.

M
That's ....

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Okay, I think we're good. Thank you for that great discussion. Back to you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great, so tag, I'm it under tag team wrestling mode here. Electronic prescribing, I'm not going to say anything about whether this could be a quick conversation or not. As everyone knows, the electronic prescribing stage one was the 40% requirement. And then proposed stage two is at 50% of orders, outpatient and hospital discharge, need to be translated as electronic prescribing. So that's moving it to the hospital side as well now. I think that was one of the changes, right, that it was just on EPs for stage one and now it's on hospitals as well as EPs. Then the proposed stage three is that 80%, so that 50% goes up to 80%. With the comment, and I think this is pulled right out of the Meaningful Use Workgroup, so this is just a comment from them that the receiving pharmacy cannot accept electronic prescriptions automatically, generating electronic fax to pharmacy okay.

So just a little bit of background here, in 2009 26% of all office-based physicians ePrescribe. I think the fraction of actual prescriptions is lower than that, although I think that the numbers have been increasing rapidly over the last couple of years. This is from a 2009 report, and I think that those have been increasing rapidly. Some of the issues are the controlled substances, right now there is an exemption for controlled substances. Should that be removed now that the DEA has come out with rules around that? Should two factor authentication be included in certification? Certainly the Privacy and Security Workgroup has talked a lot about authentication, the tiger team, so perhaps Deven or Paul could give us some perspective on that.

The readiness of hospital ePrescribing, and that's certainly an important issue as we think about this, that the hospitals that have now been added have been moving from stage one to stage two, and then what barriers need to be removed other than pharmacy participation. I would just note, I think—and I'll just throw this out here to get reaction—that one of the biggest obstacles I think in the past, at least in our experience on the ambulatory side, has been the charge that for a lot of physicians the electronic health record vendor will charge a certain amount, $25 a month or whatever it is. From their perspective there was no real incentive to move beyond, even if they wanted to do it electronically, they could generate a fax on their end, they were using the order entry system in their EHR, and it was generating a fax to the pharmacy. Why do they care? It doesn't matter to them, and why pay $25 a month to get beyond that? Now we have $44,000 to $55,000 per EP that's telling them that it might be worth it to you to pay that. So

it's just my personal opinion that perhaps one significant barrier in the past might have been removed just by providing enough financial incentive to do it in a different way.

Let me throw it open for people's comments first. Yes, Steven?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
First to answer your questions below, I think the exemption for controlled substances really should continue, certainly for stage two.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Because?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Because two factor authentication is a complexity that is not ready for primetime at execution level. It's not that it's not technologically feasible. It's just that it is not going to happen now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Is there general agreement on that? I would think that there would be.

M
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I would agree with that.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
It's not that it's not desirable. It's just not happening. I think we need to have exclusion criteria that work, and again I'm not trying just to lower the bar so it's meaningless, but again, examples which may help. I don't know how many different Walgreens pharmacies there are on Michigan Avenue in Chicago, but there's a lot. If you go to an emergency department and the patient says I went into the Walgreens pharmacy on Michigan Avenue and you say, well, what's the address? I don't know. It's the one on Michigan Avenue. Well, which cross street? I don't know. If you're in a primary care doctor's office, and they all have their own challenges, but if it's your patient that you know over time and they always go to the same pharmacy, you take time and you set it up, and once it's set up it works. But when you have a fast-paced ambulatory care practice like an emergency department or a lot of episodic care, like an orthopedic clinic or things like that, just the time required to try to find that is not insubstantial.

The other challenge is when you have people come in to a hospital setting. Our hospital is in Lexington, Kentucky, but we serve a two to three hour catchment area radius by car, well, then them telling me they want a prescription sent to some pharmacy on a street corner somewhere, I know it sounds easy, you just query, it's not as easy as you think. So a lot of times you actually need to give them the prescription because they don't know or even someone says, I don't know where I'm going. We're going to find one that's open on the way to the highway on the way back and get that. So there have got to be some exclusions for that.

Then real quickly a few other things, there are situations where, say you have a surgeon who does 80% of their available work in the hospital but only 20% in the office, but they don't qualify as a hospital-based eligible provider. So then they're reliant on the hospital to provide them data for whether they comply or didn't comply for electronic prescribing, because they can get caught up somehow. I'm giving this example clumsily, but there's circumstances that you can create where this surgeon gets into trouble because they need the information from the hospital for whether they fulfilled, because they qualify as an outpatient physician—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
They're in the hospital system, but they're outpatients.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
... but their work is done mostly in the inpatient setting. Then I'll just mention it here, it's outside the scope of this but it's so germane, is ONC's got to leverage CMS to fix the lack of synergy between HIPAA and HITECH for the eRx because it's creating confusion for what doctors need to do. That's a big conflict right now.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Faxed is one part of that, right?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Faxed?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes. What do you see as the – you know what, let's slide that.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
We'll do that offline. It's a placeholder. It's like the lawyer saying I object just as a placeholder. That's it for now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Deven?

Deven McGraw – Center for Democracy & Technology – Director
Regarding your questions about that two factor authentication being included in certification, this is actually something that we have not discussed with—I mean, we have talked about it at the tiger team calls recently. We actually got some feedback from the Policy Committee about this, but it looks very likely that we're going to be teeing up for the Policy Committee a recommendation that for participation in the Nationwide Health Information Network that a minimum level of two factor authentication ought to be required. So the next stage is thinking about whether for certification for stage two we ought to try for a requirement that the systems at least be able to handle the two factor, certainly we're going to need to be able to do that if we want the controlled substances to be in by stage three. But I wouldn't disagree that from a meaningful use perspective that it's probably too early to say that for stage two we could include the controlled substances in this measure for meaningful use.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, okay.

Deven McGraw – Center for Democracy & Technology – Director
Which is different from setting the ball in motion for certification that the systems be able to handle a two factor process.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think Deven brings up a really good point that we want to think about. In order to be ready in stage three we can't introduce a requirement newly to a market. In stage three I think we have to have shown progress towards, if we're still at zero percent controlled substance use but ePrescribing at the beginning of stage three, it's going to be hard for us to imagine that we can jump that line. So certification is one of the mechanisms to move ahead of meaningful use so that the group of docs that are ready to move forward with that can do it, we can see what's working and what's not, we can fix the policy problems, and then we'll be ready in stage three. Part of our job is to think about how to allow certification to get ahead of meaningful use, such that we can make the progress we need to make so that we can get there in stage three and it's a complicated dance in our heads, but I think that's a really critical point. So we did that, in stage one there were areas where certification advanced ahead of what the requirements were, and that allows the progress we need to get where we want to get.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm wondering whether 50% is too low for stage two.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, it's 25% higher**.**

M
It's 10% more.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Ten percentage points, yes.

M
... discussion earlier, I've never understood as long as we've narrowed, kind of like what we've talked about broadly, as long as you've narrowed the field of what the percentage applies to—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So you allow the exclusions specifically and then say it's75% or 80% or whatever.

M
And I don't understand why people don't just do it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. If there's any one that we can push hard on, this has got to be the one.

M
Why would you say, okay, I've reached my 50% threshold and I'm going to stop and I'm going to pick up the pad and start writing?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think you bring up a very valid point. The problem is for a lot of these I have a real issue with just how we use the percentages and the thresholds, because at some point they become irrational. It's either you overcome the barrier to do it and then you do it every time you can, but you don't ever really want to. We'd better be very clear when we set things to 100% because there are always cases where it won't work. So it's pretty much get to do it whenever you can and you set a threshold that allows so you don't have to track all the minutiae for all the little rare times it just doesn't work, so you don't punish someone. Because I think when people start electronic prescribing, and the high volume people are going to be primary care providers, when they re-think their processes. Because the ones who have done it, it's hard as heck for someone who hasn't done it to conceive of how is my life going to change, but the ones who have changed and automated the refill process and things like that, then I think they really like it, because it saves them time. It's just hard as heck to conceive of getting from A to B until you've done it, and expensive in a lot of settings.

Then you've got to make sure you don't have, really, this is interesting, some bizarre examples have come up now, like I use the example of an eye specialist who does ... injections, and they give medicines but they don't prescribe to the patients when they leave. But otherwise they're going to be subject to meaningful use if there's not an exclusion for some of these people who aren't going to otherwise prescribe, they may find themselves writing prescriptions people don't need in order just to not get penalized.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, so are you speaking against raising it?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
No.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And raising it to 80% now, 90% now?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I guess I'd have to look at, other than the summary here, and see how you define it and then what are the exclusions. So the patient says, Doc, I don't know where I'm going to go. I want the prescription. So there have to be exclusions for that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Then the EMR through certification has to be able to capture the eligible exclusions. So when it comes to the prescribing part you can click this one applies, this one applies.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Because we need the EMR to calculate—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, because it's not going to be a part of our recommendation, that—

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I thought there was a patient preference—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I thought there was too, but I don't see it here.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... in the original. I don't think all that's detailed here, but I believe it was based on patient preference. I think that that was already built into states, which I presume all of that, unless it's explicitly stated, that things would carry over, the—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, so if there was a corresponding requirement that systems are certified to capture exemptions, are we comfortable with raising this above 50%? I guess a separate question is, for both hospitals and EPs, or is there an argument, I don't know the hospital environment well enough, but is there an argument that if this is the first year for hospitals maybe have it lower than EPs? Hospitals have more infrastructure than EPs in general.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Gosh, you know it's tough. It's—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
... to decide this for all hospitals across the country.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I'll get hate mail in my e-mail. You know what's difficult, because you know how a lot of hospitals are going to—that's the first half of my e-mail correctly, we just won't give the domain. What's really hard to imagine, a lot of hospitals are going to fulfill some of these by taking their highest volume department, the emergency department. They're going to not even implement in the inpatient units in their first stages of rollout, they're just going to say the ER's going to do it and that's how we're going to make sure we qualify for our meaningful use money in our first stage of implementation. So I can't give you a one size fits all,

because if they're going to ding one specific department because it's the highest patient volume department, then it's going to be perversely specific to a single department initially. Now, as the thresholds go up they'll have to reach into other areas and then it will change. I think the threshold, all of this is kind of educated, making up a bar. I think you can raise it perhaps, but you have to leave it low enough so we don't have to track all of the minutiae for when it just doesn't work.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, okay.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't know what that is. It may be 70%, it may be 75%. I think 80% and 90% are too high because I don't—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So maybe that can be a part of the conversation. Is there general agreement that raising the threshold would make sense, with the import caveat that ... we need to figure out what's the appropriate level and some justification for why we would have it at a particular number. I don't know how hard the justification is for 40% or 50% either.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I don't know that I agree with just overly increasing the threshold on stage two for both outpatient and inpatient. First of all, I think the proposed stage three is 80%, so increasing the threshold on proposed stage two from 50% to something between 50% and 80%, I don't know that you could—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
You can make it 60% and it's a straight line.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, some people would say 50% is perfect. It's a perfect stepping stone for 80%, but I'm wondering about the splitting between outpatient and inpatient more than that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Peter, what's your experience, Epic's in both.

Peter DeVault – Epic Systems – Project Manager
I think Steven's points are important, that unless we're prepared to account for every situation that's a fair exemption, that we should basically think—well, we're trying to do 100% but we can't account for every exception. So let's make it something less than that so we don't have to keep track of all of those exceptions, and make it 80% or whatever it might be. I do think you're exactly right, that a lot of hospitals are rolling this kind of thing out first in the ED. That's a great test bed for all kinds of new workflows and technology and functionality, and that happens in just about every hospital we implement. So I think that for the first year that we're requiring it for hospitals, if we can figure out a percentage that makes sense where we're touching the EDs but maybe not extending out to the rest of the hospitals. Whatever that percentage might be, and I don't know of a number, but I think that would make sense for hospitals.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here's one quick suggestion, for example, you can go on stage two to 70% on ambulatory and stage three 90% ambulatory, and on stage two, you can go 40% inpatient and 70% for stage three. That kind of parallel progression I think might be possible.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. If people are generally comfortable with the idea that we want to raise them with the idea that we probably want to consider separating the EP slope out from the hospital slope, we can leave that for the follow on work that we'll do after this. Okay, great. Thank you. Next?

W

About half an hour.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Now they're going to get easy. This one's really easy. This is just about HIE itself. Now we have one that's, I think, pretty complex to think through. Hopefully I'll be wrong. Perform test of HIE was the original formulation for stage one, and I hope Allen can shed some light on what that has turned out to mean. Then the proposal for two and three is to move to this split approach, with the "or" being important there, either connect to at least three external providers in the primary referral network that are not part of your EHR network, or, establish a bidirectional connection to an HIE to be defined later on today. Then that would just go up from being at least 3% to 30% in the proposed stage three approach.

The comment here is to remind us this may require the use of provider directories, so several questions have been posed for our discussion here. Does this become moot because other objectives, like care coordination objectives, will pull enough HIE traffic that we don't have to specifically call out this function here. Secondly, how we're going to define bidirectional. Do we need to define what the data packet is that's being exchanged, or is it just exchange as a verb really without any substance behind it? Then we'll talk later on about the qualified entity construct.

I'd appreciate it if anyone can shed a little light as to what is meant in the immediate stage one implementation to just perform a test. Allen, do you have any sense of that at this point?

Allen Traylor – ONC – Meaningful Use Policy Analyst
I haven't read the summary document. I did pass on the query that it was completed late last night, so I haven't had a chance to read that document yet.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Does anyone, informally, in your own experience, have a sense for what that's turning out to mean?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, I've got to say a few things about this one because I've spent a lot of time. Basically, pretty much any entity that is going to meet stage one will have performed a test and more so. If we're talking about performing a test of HIE in the upper case HIE version, which in many places might mean connecting to an actual HIE, that's different. But in the context of conducting health information exchanges externally, that's what meaningful use stage one and many of the requirements mean. I have a lot of trouble with this particular requirement because I didn't understand why connecting to three external entities would be affected at this stage two level, when in stage one you're already connecting to a lot of others, a lot more than three for sure.

So my sense is we don't need to have a threshold of three external entities, that seems to be too arbitrary and again, it's fulfilled already in stage one, so the first point kind of makes that. And I think if there's anything about this particular measure is about state HIEs and it's about connecting to HIEs. Not the state HIE, but a regional HIE or some sort of formally connecting to an HIE. I don't know the reason why these three entities appear in this particular one. It could be used more to encourage people to join and to participate in state HIEs.

M
It sounds like Peter has another measurement. It is a test and a failure actually is a positive result here. So you can fail at it and still succeed in the measurement. It's just a simple test that's—

M
How is the word "test" operationalized in the rule?

Peter DeVault – Epic Systems – Project Manager
I can tell you what some of our customers do. We have an interoperability platform in our EHR, we call it Care Everywhere, and most of our customers have implemented it now. But some of them have just

implemented it in their test environment because there are no immediate trading partners in their vicinity, which I think is why it became a test of HIE to begin with in stage one. So what they've done is simply, in their test environment, connected to themselves and exchanged information. That's allowed them to satisfy the meaningful use objective.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
If I'm required to do 40% of my EP for ePrescribing electronically, why wouldn't that already meet the requirement of testing HIE?

Peter DeVault – Epic Systems – Project Manager
I don't remember the exact requirements, but I thought this had to do with being able to do a care summary.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think, I shouldn't speak for this because Allen will just shoot me down, but I think part of the issue was that there were a bunch of requirements like labs and care summaries that weren't being required to be transmitted electronically but we still wanted to build the capacity for electronic exchange. To the extent that we, in particular, have recommended moving those measures into electronic, I think you could ask whether a test of an electronic exchange is necessary on top of it, and I'm guessing that the answer is no. I think this question of whether you deem an intermediary to be your service provider to help you accomplish things and give you credit for that, is probably a question we can leave until this afternoon's broader discussion, and that is the one that Walter was referring to.

I think that the two parts of it are, the test was useful in stage one because the other requirements weren't electronic, but we still want to have people demonstrate they can do that. Part of our communication could be we support moving those electronic and as such this one starts to go duplicative, because you're already sharing lab results or a care summary or ePrescribing, and we don't need another test of that. We don't need another demonstration of that.

Peter DeVault – Epic Systems – Project Manager
That may very well be. If we are going to have a discussion later about whether an intermediary is required or whether we can do direct exchange, I'll save those for later.

M
... a question, and maybe I'll ask Claudia for her thoughts on this. If someone actually is an early adopter and so they began this year, and so October 1 they start their three months, they fulfill stage one, and in 2013 if we keep on the current timeline, stage two will be applicable to them, correct? They'll have to meet stage two to get their next tier of incentive payment. So I guess my question or concern is, and this is appropriate to the IE Workgroup, is will there be enough robustness, will there be enough trading partners that we won't have people fail, I guess, depending on what they have to exchange. Because I think we're designing or we're thinking about a lot of things that could come to fruition in the coming years, but will it be up in time, 2013, 2014, for people across the nation. I just don't know. Then two, there's electronic prescribing the pill ... because you're exchanging with scores of pharmacies perhaps information.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think we've been reflecting this, it's a hard one because we know that by moving to more rigorous requirements we're moving the field and we desire to do that. We don't want to stay put where we are. At the same time, we want to give people a safety valve so they're not ... going to be able to do things they can't do. I just think that's a balancing act in our "where available" language. Of course that's tricky to define, but I think all of that, and I do think yes, the ePrescribing one, but I think the bigger question is do we even need a test of HIE if we have more rigorous requirements than the other, that's the bigger question.

Peter DeVault – Epic Systems – Project Manager

I think we were directed to make our customers understand it in this way as well, is that this is not an ePrescribing kind of requirement. This was meant to be, you're doing XDS.b or XDA to move a continuity of care document around different than ePrescribing or lab results.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Allen, do you want to just briefly describe what the parameters of the taskforce are?

Allen Traylor – ONC – Meaningful Use Policy Analyst
Yes, I do want to step back here just really quickly, though. Performing a test, it has to be with a different entity. You can't create a test of what's in your environment and have that count as a test. It has to be with an external different system. So you can't test with yourself.

M
I probably misrepresented that. They connect to other of our customers' test environments.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
....

M
I'm sorry. I just wanted to clarify. Then what was the question?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Did the expectation here build in specific standards requirement or other things that move into more of a robust exchange expectation?

M
... particularly with the standards, but I don't think that it's necessarily there, and I think that's why public comment is open, to flesh a lot of this out.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... I do exchanges with immunization registries, do exchanges with labs, do exchanges with pharmacies, and do exchanges with other providers, and any of those would quality to meet this particular performance test for HIE because there's no restrictions. So I'm already past and beyond that and pretty much anybody that meets stage one will be past and beyond that. So they have done at least 40% of the electronic prescribing electronically and would have met the ... test for HIE.

M
Electronically is very broad, as we were discussing earlier, and I don't think this requirement was quite as broad as if you're doing your ePrescribing then you meet this objective.

M
This was the intent of this particular requirement. My understanding—and this goes back to Claudia, your original comment about there being a ... involved program for statewide HIEs that there's a real desire to have, and other comments at the beginning—that there's far more desire to have a robust infrastructure to exchange various forms of clinical information and that these programs. These state HIE programs have been funded to the tune of $600 million. Some of them are standing up robust HIEs or supporting or standing robust HIEs in the state. What this could do if it is properly and appropriately defined as a measure, it would allow providers in some of those catchment areas, whatever, to connect to that service or those services that support robust HIEs, bidirectional, query response in some cases, health information exchange that allow them to fulfill things like ePrescribing, lab, ... shared document exchange, etc. So I think what I would suggest we maybe do this afternoon is try to clarify what it means by connecting certain bidirectional interface so that we're not confusing the market by saying ePrescribing counts when it's much more robust than that and we should define what a connection to an HIE really means.

M

... again. It's key clinical information. So ePrescribing is key clinical information about a patient and that can be left up to the provider to decide what that key clinical information is at this point, but if it's available in structured format it has to be transmitted in a structured format, but if it's not then it doesn't have to be transmitted that way. But this is key clinical information. This isn't just an ePrescribing measure.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm sorry, Jim.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Actually, I had some questions and maybe this is the right time or maybe this is best left for later. What I didn't quite understand a little bit about the proposed stage two, is I think there were just some terms I just don't understand. For example, when it says "connect to three external providers" I guess, to Jonah's point, what counts as a connection? What makes it even a little bit more confusing to me is I would have perhaps thought that that connection had to be bidirectional or you needed a relationship with those three. But then later in the text it actually described a bidirectional connection, implying that perhaps the first one didn't have to be bidirectional, because we use the adjective in one spot but explicitly don't use it in another. The words in parentheses, I'm not quite sure I understand how those are supposed to be read together. So you have to have three external but outside delivery systems that use the same EHR. Is that saying it has to be a different delivery system, so it's not part of my legal entity but that they have to be using the same EHR, or that they can't be using the same EHR?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I just think that it's an unaffiliated provider. I'm not actually certain what the EHR ....

M
Yes, our—

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... that they can be on the same EHR, but it has to be an unaffiliated one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We have a number of complicated questions overall asking repeatedly. I wonder if we can back up a little bit and think about the meeting the Meaningful Use Committee's having shortly, what we want to say to them at this stage. It sounds like we all have an interest in this kind of work going forward, and we can make a list of ten important questions that need to get answered to move the process forward. Today we're not going to have time to answer most of these questions. I can see they're all going to be thorny, even the word "bidirectional" and what the content of the test should be and whether it's test or a functional operating relationship, and who's the qualified external provider and who isn't, and all those questions. And what HIEs are available to support this, and what does it mean to have an HIE, and if you're in a white space area that doesn't have that capability regionally relevant, are you just going to artificially connect to an HIE in Florida because you can, or etc.

For our immediate purpose today does anyone have a sense of what kind of recommendations we want to make back to the Meaningful Use Committee and what do we want to take on? For example, we could take on for ourselves a work product for the next month or two to answer some of these questions as best we can and make a referral back by May, let's say, to the Meaningful Use Committee.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
One option would be to defer this to this afternoon when we've kind of threaded it a little more holistically, and even if we don't have time to fully have that scope question and how we want to go forward question then, because we have a couple of slides that frame it up a little bit more.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Do you mean qualified ...?

Claudia Williams – ONC – Acting Director, Office State & Community Programs

Yes, because I think that's the issue. There are some other issues but that's the one that people are really stumbling over.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
James?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
One thing that I would suggest as a recommendation going forward, I do think that this is a critical issue for HHS between ONC and CMS in that ONC has invested half a billion dollars into having the state deal with exchange, and that could be state HIEs—it could be robust exchange. It could be helping to develop the infrastructure to support Direct, there's a variety of activities that one could do at the states, but there's clearly limited funding. So I think that this is intended to help direct the state's activities in whatever activities we're going to do to support exchange at a state level. So I think sorting out how the CMS meaningful use requirements tied to the programmatic activities of ONC are pretty critical and so I definitely think that the one recommendation I would say is that they should think pretty carefully about how they want those two programs to tie, because it is going to drive the state level work.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I know I put words in your mouth, Claudia, but I think you may have asked this question earlier. If there are other requirements that require ePrescribing or require taking lab data in structured format and providing a transition summary, and transitions of care, and those individual requirements are beginning to require and move towards in stage three the electronic exchange, is there a need for this as a discrete separate item? Because the other ones are already requiring us to achieve that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That is exactly the point I was trying to make, and you made it even more clear. I think the only place where this, in my mind, fits, is not so much in the connecting to three external, it's expecting that entities will connect to a state HIE, a regional HIE, or to an NHIN via the NHIN, but create an expectation that that is what is needed.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Walter, what I think is another way to put that is not to say "required" but say "allow for the use of such a service to help you satisfy." And that's a conversation we're trying to tee up this afternoon, is independent of the test of HIE, which I think we're all doubting is all that useful, to what extent would we want to allow an intermediary to fulfill and perform some of the very same requirements that we've already teed up. So that's the question I think we want to deal with this afternoon.

A secondary question is whether to the extent those entities can do more sophisticated exchange, more bidirectional, is there a way to get meaningful use to move in that direction more rapidly. I think the challenge there is they're uneven across the country. So that's the set of discussions, I think, but I would flip it and not have this require a specific network. I don't think we would ever go there with meaningful Use but rather say allow for the use of the capacities that exist and that would give a strong message to the participants in states to say, wow, this could be really helpful to me in doing what I need to do.

Deven McGraw – Center for Democracy & Technology – Director
I just want to speak to, sitting on the Meaningful Use Workgroup, I think the intent here was to create optionality. If you want to connect to your state HIE, that's one way to scratch this box off. If you're using Direct and you're sending documents to providers and referral networks that you participate in and you want to use that option to check off this box, I think that was the option there. But I do think that the intent here was really to get at some of the care coordination aspects of meaningful use, which is not necessarily to count ePrescribing, not necessarily to count your receipt of lab results, but really to look at the transitions of care issue a little bit more directly. But I think a list of questions that get raised by this from this workgroup would be incredibly helpful, particularly on the do we have the capacity, do we have the right sets of standards in place. Because I do not think the intent was to say if you're ePrescribing and getting labs internally within your own organization electronically, that that counts.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It sounds like we have some agreement that the goal here is to not be too prescriptive about what technology platform or architecture is used to get these messages moved around, but to keep our focus on the—as Walter said earlier—the ability of the network to receive those messages to improve care. We'll talk more this afternoon about the HIE itself and whether we want to qualify it. For now, I'm almost hearing not quite a recommendation, but a lack of enthusiasm for this being a meaningful use strategy going forward per se.

M
If you have any questions, we can do that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We have a couple of calls between now and April 5th, right, so those might be the ones we can work on, on the calls, the ones that are going to require some significant rework.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
... lack of enthusiasm for a test of the HIE without more clarification or more description of how that goes beyond the other requirements, but an eagerness this afternoon to talk about those other concepts and really figure it out.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
As you look to stage three, and I know we're not here for that, but as you define things like connect to 30% of external providers through a primary phone network, some of these things get kind of fuzzy about how you define that. So I think the goal is we want to have transition documents going to the next provider, so I think this almost this would be better subsumed into more specific requirements elsewhere.

M
Almost ... to see if there is a consensus in the way that Steven just formulated it, that our primary interest is in saying that the transition documents of various kinds are successfully transferred not to prescribe one format architecture or another for that to happen.

M
... which I don't think you're suggesting or anything, but not to lose the concept that we want HIE embedded in meaningful use, which there's a different way to articulate that within specific measures.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes, right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
One other thing that hopefully isn't a wrench in here is that I think some people are interpreting this particular objective to be about a different use case, which is not about transitions of care, but is about the summary of care. Which is to say that I'm not pushing a document post encounter, it's more about being able to just generate a summary, a full summary, the key health information, whatever that is, and be able to send it or consume it outside of our particular episode of care and be able to demonstrate that capability.

M
Is this more about pull than push?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
It wasn't intended that way. It is not intended that way.

M
Okay.

Deven McGraw – Center for Democracy & Technology – Director

I've had people say to me that meaningful use stage one requires that everyone participate in a state HIE program, and they point to this. So there is just a lot of confusion about this measure I think out there and what it means and what it's meant to mean, is it a query, is it bidirectional. So I think we would all be well served by whatever happens having a much clearer –

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think to Jonah's point, we don't want to create an artificial business use case—an artificial business case, which is to say well, we know that we're spending a lot of money on state HIEs. We want them to be successful and sustainable, and now we have to create a business for them so we're going to require everyone to talk to the HIE and create a silly loop which has no intrinsic value to anybody except to satisfy this. If we can't create value because we want care summaries to end up in someone's hands, that creates value. Then the HIE can figure out a way to satisfy that value in a sustainable way past 2013. This would be a little bit artificial to say transfer something using an HIE. We'd rather say transfer "x" because it serves a patient care goal. Okay, so we solved this one, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Okay. I'm going to suggest, we're a little bit behind on the schedule of going through these—

M
....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, it's hard to believe. I know. I'm shocked by it. But I would like to keep lunch on schedule, if that's okay with everyone. So, can I just suggest we pause for lunch and then we can sort of figure out off line here how we want to restructure the afternoon? How much time should we have, half an hour?

W
....

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sorry? Okay. What are the lunch options here, if it's going to take people 20 minutes to go and get lunch.

W
There's a Chinese place and a sandwich shop.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, sit down dining is not an option.

W
... sandwiches.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think we need to leave it at 30 minutes, though, I'm going to say.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Yes, around the corner to the left there's a Breuger's Bagels, there's a place called Light Stars, which is the most fat-free, salt-free food you could ever want to order. So if you're on a strict diet—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
These are not government endorsements of any of these.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
They're not. I've eaten there. I try to watch what I eat. But it's pretty austere, even for me. But it is there. But Breuger's Bagels, and there's also a little coffee shop .... You make a left around the corner

and there is, Me Wau, which is Chinese, which is across the street. Those are probably the closest options within a very tight radius.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Thanks to our local expert. Excellent. All right, so 12:30 we will start again. Thank you, everyone.

(Lunch break)

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if Seth Foldy is on the line, please?

Seth Foldy – Wisconsin – State Health Officer
Seth Foldy is on the line.

Judy Sparrow – Office of the National Coordinator – Executive Director
Seth Foldy, thank you. Okay, now we're ready to begin. Thank you very much. We are ready to resume the meeting and I'll turn it over to Micky Tripathi.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome back, everyone. So, I think in the interest in time, we know that Seth is in the house. Is Jim Buehler? No, but can we proceed with the public health with just Seth and Jim Daniels here, and Jim Golden will be back, okay.

So, what I would propose that we do is jump to the public health objectives while we have the public folks here. Walk through those and then we can go back and start with the medication list and medication reconciliation, which I think is a big one, an important one and is probably going to talk a little bit of discussion here. Then I would suggest that we just see where we are at that point. It could be that some of the ones—because starting with list of care team members, which is on slide 22, page 11 going through the next few, those are genuinely new ones that perhaps we can tackle in a phone call because they are new, so people don't have background in them. Maybe those will take a little bit more time than we want to take here. But I think in looking at the schedule, we've probably allocated more time than is necessary for the last agenda item, which was the qualified entity and other topics; that's two hours we've allocated for that. I think we probably won't need more than an hour, so it may be that we have a little bit more time.

So, what I suggest, we start with public health, do med reconciliation. We can see where we are then and then decide whether we want to tackle some of these other ones now or save those for a phone call and then jump to quality measures and the qualified identity. Does that make sense to everyone? Okay, great.

So, why don't we start then on slide 27, page 14, which is Immunization Data Reporting, right? That's the first public health one I think, yes. On this one the stage one final rule had—well, it was the submit immunization data, which was a menu set item, except for the caveat that an eligible professional did have to choose one public health from the menu set. So this was one among a few that were in the menu set, but they did have to choose at least one. The proposed stage two is the eligible hospital/ineligible professional requirement, a mandatory test where some immunizations are submitted on ongoing basis to immunization information system if accepted and as required by law. That's what's in the proposed stage two and then it looks like it's the same in stage three with the note there, as you can read, I'm going to turn to this because that's a little bit blurry.

The comment from the Meaningful Use Workgroup is that stage two implies that at least some data is submitted to the Immunization Information System that the EH and EP may choose not, for example, to send data through IIS to different states in stage two. The goal is to eventually review IIS generated recommendations. I'm not sure I fully understand that, but, hopefully, our public health colleagues can help us understand that. Some of the issues to consider that we had flagged as the standards mechanisms for reporting are more established and in use compared to other public health objectives. I

think those in the states have certainly seen that. Public health is most compared for this objective as compared to some of the others, and then a question, what needs to happen now to support bi-directional IIS use in stage three.

So, let me ask—I don't know, Seth or Jim Daniels, Jim Golden isn't back yet, can maybe kick off some of their comments on this and thoughts on this and then maybe we can open it up, does that make sense?

Seth Foldy – Wisconsin – State Health Officer
I'll just issue a few comments. I think I was not aware that we were going to be marching through these, otherwise I would have tried to have our Immunization Information System program people looped in. So, I can't be sure; I know there would be other valuable input, but I know that at CDC we've had broad discussion over some of these questions. We do concur very much with making testing and subsequent ongoing submission a core stage two objective. We think it will have great health benefit in the long run.

There has been raised, with regard to electronic laboratory reporting, but may also be a question to be considered here. This is a separate question as to whether or not providers who are already successfully electronically transmitting information to a public health system. In this case, an immunization registry, if they are successfully transmitting using non-HL-7 v2 messages, if that is already implemented and is acceptable to the public health agency, whether or not some level of grandfathering might be desirable to include. That is to say, if you're already doing it the legacy is working and the data is flowing. Is it important for both the provider and the public health registry to then re-engineer it up a new HL-7 v2 standard? Or would time be better spent allowing public health agencies to onboard new users using the new HL-7 v2 standard while continuing to maintain transmission using legacy standards and allowing those early adopters from long ago to participate in the meaningful use incentive? So, that was a policy issue that has been raised and not really answered yet and it may have some relevance here.

I have about three other points, I think, related to immunization data, and I don't know if you want me to blurt them all out and then we process them or if you want me to stop and we go through them one at a time?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Why don't you blurt them out.

Seth Foldy – Wisconsin – State Health Officer
The next issue there is some language in the HIT Policy Committee letter about, "if accepted and as required by law," which is slightly different than language in the stage one role. And there are two concerns about the language. It doesn't actually specify, first of all, if you're talking about immunization reporting is required by law or electronic immunization reporting is required by law, so there is some vagueness there. Second, we point out that much immunization reporting occurs because it is authorized and allowable by law, but not necessarily required by law. So that a required by law statement may actually serve to constrain immunization reporting's attractiveness here when you have many people already submitting the data, even though it's authorized by law or permitted by law, it's not necessarily required by law.

Finally—

W
Seth, I'm just wondering from the MU Committee; I read this two different ways. When I first read it I read it as if required by law and the second time I read it, it was more like in the format and way in which it is required by law.

Seth Foldy – Wisconsin – State Health Officer
Exactly, I think the ambiguity needs to be cleaned up, just language-wise. Again, immunization registries do not necessarily have laws or formal regulations that dictate how information is received by the immunization registry, so the use of the term "by law" may be prejudicial. In others, practice may be as important as law.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Seth, as a reference, I think you were looking for the original language or referred to. The original language says, "In accordance with applicable law and practice," which is different than what is in this, "if accepted and as required by law." So, yes, I think it's very important to clarify that.

Seth Foldy – Wisconsin – State Health Officer
We thought the original was probably more appropriate, although there may have been problems with the original that we're not cognizant of.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Go ahead, Seth.

Seth Foldy – Wisconsin – State Health Officer
And then my last point, although I'm not going to be able to dive very deeply into the technology, but we do strongly endorse the Committee's attempt to make clinician review of Immunization Information Systems part of meaningful use in stage three. That is to say, when you say during well child and adult visits providers review immunization information records via their EHR, we think this is a very good thing that will drive much further health improvement. We do recognize there is more than one technical model for this. For example, porting through your EHR to actually view the IIS application is one method. Important alerts into the EHRs decision support system is a second method and I don't believe that we are ready, and this is why I wish my immunization colleagues were with me at the moment, I don't know that we know which will be most practical by the time 2015 rolls around.

So, those are my comments on immunization.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Jim Daniels or Jim Golden, did you have any other comments on public health.

James Daniels – Medical College of Wisconsin – Associate Director
Yes, sure, I can comment a little about in the beginning Seth brought up, you know, what do we do with these legacy systems who aren't submitting 2.3.1 messages. There are a lot of transfers going on through CSV and I think those are not going to meet meaningful use per the regulation. Seth, did you have a comment about that? So, I think if we read the regulations that's definitely the case.

The other thing that I think is important to remember is for this year the people who are going to need to actually start sending data to get their incentive payments are the Medicare incentive payers. Those are not necessarily payers that providers that have a lot of data that is interesting to immunization registries, so it's sort of an interesting thing. It's good in a way because it does give us another year to think about those people who are sending data in a legacy way to try to get them up to speed and get the immunization registries up to speed to accept a 2.3.1 message. Because those early adopters of sending immunization data electronically, they're not Medicare providers because they have large pediatric populations. So, it's not necessarily something that we have to worry about this year. I think it's more next year and working with RECs and the HIEs I think we can come up with some models to really help both the providers and the immunization registries get the infrastructure that they need to both send and receive that data.

Deven McGraw – Center for Democracy & Technology – Director
We were sort of walking through some scenarios last week and if you remember that every provider has to do one public health measure and you're off the hook if you can't do it. So, if you just walk through the scenario of an internist with Medicare patients, so they don't do ELR because ELR is a hospital measure. And if they, by all rights, if either the Immunization System is not ready for them to do the flu vaccine immunizations then they would be doing syndromic, which we'll get to later, but probably is maybe the least ready. So I would just wonder if, in light of that sort of scenario, if we actually do need to make enough progress that docs have the option, even if they don't have a lot of interesting data, to submit immunization information on their over 65 population this year.

James Daniels – Medical College of Wisconsin – Associate Director
And something Seth didn't particularly say, but I've been doing the comment review for this and it's brought up over and over both by public health agencies who have responded and other people as well, that public health agencies don't have the funding to really build their infrastructure to meet meaningful use requirements for these providers. So that is something really important to consider, so if there are things that especially an HIE can do to help them support that infrastructure, I think that's really important, especially for this first year.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I'd like to echo Jim Daniels' concern. I think there are lots of health departments that probably aren't prepared to be able to deal with the immunizations and funding is particularly tight at this date, so I'd like to say that. Fortunately, in Minnesota, we actually have a pretty strong immunization registry and we've been giving stuff through Web submissions for quite some time. I think what our people would say is that it probably needs to move beyond just submission. If you really want to impact the effectiveness in the delivery system, you really need bi-directional exchange so that the providers can see when someone is missing an immunization and when they need to deliver that. And so, I know one of the big pushes we have had in Minnesota around this has been around the need to have bi-directional where it's feasible and possible.

Seth Foldy – Wisconsin – State Health Officer
This has raised some concerns between the immunization registry community and the provider and vendor community where today people are stepping, I should say eligible providers and hospitals, are stepping forward to hook up with registries and, in fact, are being told that the registry expects a bi-directional relationship this year and not at some point in the future. So there is some degree of negotiation going on as to whether pre-existing registry expectations and the more unit directional standard in the ONC and CMS rules, how those play out in a given jurisdiction. I think that needs to be in a sense negotiated by the partners in those jurisdictions, but you should be away that there is already some expectation on the part of some registries that they want to go there sooner as condition of participation.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Walter, and then Jim Daniels

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I have a couple of comments on this one. The first one is it seems like we are going from a menu to a core, but a core that just says mandatory tests and it's stage two, so it's really jumping to make it a mandatory test only, no threshold beyond just a mandatory test. It seems like we keep that on stage three, continue to make it no threshold, meaning sort of 30% or some level percentage. So that's one element that I think is of question whether we expect that by 2015 people will still be doing mandatory tests only or do we expect that there will be some minimal level of required exchange, 30%, whatever threshold it is at the appropriate stage. So, that's one element.

The other one I wanted to comment on is the possibility that today and even in stage two or, for that matter, even in stage three, entities will still be able to use multiple standards, so people will be able to still use paper, Web, Excel files like some do, or the HL-7 standards. There is no requirement really on doing a specific level of transmissions using the HL-7 standards, specifically, which is the one that is in the final rule adopted as the standard to conduct this transaction. But, again, in the meaningful use requirement there is an expectation that only doing a test will be sufficient for stages one, two and now three. So, I'm not sure—this is so soft at this point and I assume that the reasons, of course, are primarily the level of readiness by both public health agencies and providers to go all the way to an electronic submission using the HL-7 standard, whether it's 2.3 or 2.5 because both of them are acknowledged as standards.

So, my question, or my recommendation, I guess, is number one whether we need to move this into more of a transition towards some threshold level and, number two, whether we need to move towards a common standard more specifically rather than doing it too openly?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Jim, I think those are really important points and probably warrant a little bit of clarification if there is anyone in the Meaningful Use Workgroup who can give us some insights on why, to Walter's point, it's still just a test all the way through stage three.

James Daniels – Medical College of Wisconsin – Associate Director
So, I think the language in there does actually say if it's successful it's ongoing. I think we need to go back, as you suggested before, to the per practice or law because the way we've interpreted that is if it's practice in a state to submit the data then that's actually what you have to do. So as long as we get that language back in for stage two like it was in stage one I think we'll be okay because that's been the way it's been interpreted for ELR and immunization that if that's how you do it in the state then a test doesn't meet the criteria. You have to continue submission.

Deven McGraw – Center for Democracy & Technology – Director
You helped clarify this for me last week that the definition, the test embeds in itself the concept of ongoing submission if the test was successful.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So I submit data to ten different immunization registries or 50 or whatever number, depending on how many. If I send it to one of them I fulfill the test requirement and if the test is positive, if the test works then with that entity I need to continue submitting, not with all the other ones because the other ones could be.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
That would necessarily be the—you're California, right?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, it's very different.

James Daniels – Medical College of Wisconsin – Associate Director
I mean, I still don't know what California is going to do. There's a little fighting between the states and the county immunization registries, but the regulation and practice I think would be interpreted there that those counties would have to, that would be the practice is that it's submitted to them. So I think the interpretation would actually enforce what you're looking for and as long as we get that wording back in there I think we'll be okay.

The other piece that you talked about the multiple standards, I mean CSV files are not acceptable for this at all; there are implementation guides that are referenced in the regulations that call specifically for 2.3.1 or 2.5.1 and they are extremely mature standards. Immunization registries have been doing this for a long, long time. So, I don't think there's a lot of ambiguity in the message standard for immunization registries, especially maybe compared to some of the other public health measures because there are very specific implementation guides that are called out in the regs, so I think we're probably okay there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
But, Jim, I thought I heard you and Seth to be recommending that we try to grandfather existing.

James Daniels – Medical College of Wisconsin – Associate Director
Oh, I think Seth suggested that. I did not comment. I would turn to Doug just to comment on that. Maybe before we go there, I did want to walk people through a work flow to make sure that they really understand why bi-directionality is really important in the clinical decision support.

So, right now in most states people are actually doing data entry into a Web-based immunization registry. There's not a lot of one-way data exchange; there's some, but whether you do a Web-based data entry into the state systems when you see a kid or your EHR sends off the data to the immunization registry the important thing. The really important thing that you want to get out of that immunization registry is that child's full immunization record and see all the shots that they've gotten everywhere else, as well as the clinical decision support that immunization registries often supply, which is recommendations for what shots are due to that child at that visit. So, those are really important functionalities that are embedded in immunization registries. So, from a work flow perspective with either Web-based data entry or one-way message exchange, providers are still going to have to log on to the state's immunization registry to get that functionality that's so important, the full immunization record and the clinical decision support.

So, just to make sure it's really clear in everyone's mind why a bi-directional message is really important whether it's an HL-7 message coming back with a full history and recommendations. There's been some great work in, I think, San Diego actually, County, on defining an HL-7 message with the recommendations or whether it's some of the other ways that Seth spoke about somehow embedding an immunization registry piece into your EHR. I know there's a Sharp grant working on that. But that bi-directional piece is really important. Otherwise, who wants to go between two systems while you're seeing a kid; you can barely work in one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I was wondering if Seth Foldy could insert a couple of thoughts here. First, going back to Walter's, I actually do read the language differently than he does that a test is mandatory. It doesn't specify if a failed test is enough to attest to get your incentive, that's a different issue. But the language does explicitly say some immunizations are submitted on an ongoing basis and then under comments it talks about, for example, a single provider might not supply immunizations to every registry for every patient they see. But there is a minimum level, as I understand it, that if your test passes you start submitting. So, I do read it differently than I think Walter did, but, again, how much is ambiguous?

Seth Foldy – Wisconsin – State Health Officer
So, I guess I'm struck with how ambiguous all this language is, some immunizations without thresholds.

James Daniels – Medical College of Wisconsin – Associate Director
Some was the biggest comment, please describe some.

Seth Foldy – Wisconsin – State Health Officer
And just very quickly, I concur that the ambiguity of the language will ideally be cleaned up. In terms of methodology of submission and adherence to standards, that is also currently ambiguous. For example, it is my understanding in the Q&A the FAQs for meaningful use a question was raised whether Web entry of information might meet the ONC/CMS standard and received an affirmative response, at least in some cases. So there is ambiguity as to how strictly the perception is of messaging and transport layer and other things and I'm not arguing that we should abandon the standard. In fact, I'm not even arguing that we definitely should grandfather older methods, but I am suggesting that it be considered as we look at the impact on the actual flow of information to immunization registries. If it were concluded that bringing many legacy providers up to HL-7 v2 might adversely affect immunization registries' ability to onboard more providers that consideration be given to a grandfathering possibly.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Seth, if I can make a comment very quickly. The grandfathering—okay, just walking through the process, if I'm already sending immunization registry electronically using some other standard.

Seth Foldy – Wisconsin – State Health Officer
Like an ASCII flat file.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Like an ASCII flat file or an Excel file, some other format—not the one named in the regulation as the standard. I am now required by meaningful use to do a mandatory test and I do the mandatory test,

presumably, of course, under the regulation doing the mandatory test using the standard, I will fail the mandatory test because the other entity will say, no, I don't accept that. I still accept only Excel of ASCII. So, I'm done with my mandatory test and I will continue to be able to submit the data in whatever format I was using before.

Seth Foldy – Wisconsin – State Health Officer
I would modify that because your EHR must be certified to be able to send a 2.3.1 or 2.5.1 message and thus the sending of a test message would still be required presumably according to the standard, but that might be different from switching everybody's production over to the new standard. And I'm sorry to introduce the concept of possible flexibility, but our concern at the end is the ability of public health to onboard the number of new providers that may be seeking to join.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. What do other people feel about this idea? We don't necessarily have to resolve it now, but it seems like there's an issue here of some of the language confusion. I don't know if people would agree with that. It's a question of mandatory test versus doing it ongoing, it seems like there's some room for clarifying that. It strikes me that saying something more specific about which immunizations rather than just saying some. I mean, arguably, you want to have flexibility, but we're being very specific in some areas. It just strikes me as one where we can be fairly specific in this question of grandfathering.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve Stack. I'm just puzzled because I just don't know. I mean, if you have an EMR and you give vaccinations in an office setting and you conduct a test, which is required and the registry accepts it, can you set the EMR just to automatically export every new vaccination recorded. And if you can, then it's no big deal; if the technology will do it, then it's no big deal. Can that happen?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Really in the states that are set up to accept 2.3.1 messages and 2.5.1 messages, yes. I think that's exactly how it's going to happen. I think the problem is in these states where there are legacy transactions going on, the state doesn't have the capacity to accept those HL-7 messages.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So, in those cases, for the purposes of meaningful use, you did your test, the agency can accept it. You're done, until perhaps the next calendar year when you have to conduct another test or something and see if the registry is now able to accept that.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I guess that would be correct, yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
That's exactly the point I was making is really the grandfathering already exists by virtue of saying okay, I use an EHR, my EHR is certified. It's certified, which means it supports the 2.3.1 and 2.5.1 because they are already part of meaningful use stage one.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
You're basically getting an exemption because the public health authority is not ready; you're not meeting the meaningful use criteria. I think that's an important distinction to make.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right and, of course, you'll continue to comply with state laws required, which means you have to report some other way, but that's outside of meaningful use complying with state law. This is just for if your technology enables it and, hopefully, certification requires that it's somewhat automated so that the clinician doesn't have to go through some cumbersome secondary steps to do it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

But, Jim, just on our point, sorry, before we leave it, it is a distinction, the exemption versus your being meaningful use certified, but do we think that makes a difference in the market?

James Daniels – Medical College of Wisconsin – Associate Director
I don't understand the point of exception.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Because you do the test, public health is not able to accept it, so you get an exemption essentially. You're not penalized in the meaningful use evaluation or assessment.

Deven McGraw – Center for Democracy & Technology – Director
But it doesn't get you off the hook of doing one, that's the problem. So, I guess you could do that and then do syndromic and if you got exempted there, too, but it's not like getting accepted here gives you a free pass, because you still have to do one of the three.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Okay, so if you were already doing it the argument would be that if I was always doing this in the legacy way if we allowed the grandfathering I could check the box for my one public health and then not have to do any of the other ones.

Seth Foldy – Wisconsin – State Health Officer
I do think that the point that was made recently, it may not be necessary to explicitly call out grandfathering if, in the situation where the health department and the registry has accepted the test. The test passes, the provider is then enrolled for future submission using HL-7 and the provider can attest to having a successful test and being prepared to submit when public health is ready. It may not be necessary to add additional language related to transmission by older methods.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Do we think a lot of public health agencies are going to be in the situation where they can do a test, but they can't accept data on an ongoing basis? It sounds like that's what you're suggesting, Seth.

Seth Foldy – Wisconsin – State Health Officer
We are hearing that this is likely to be a bit more of an issue in the area of electronic laboratory reporting and there's much that I don't know about immunization registries and that's why I wish I could tell you more definitively.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Why don't we go to Hunt, and then Jim.

Hunt Blair – OVHA – Deputy Director
Did you want to respond?

James Daniels – Medical College of Wisconsin – Associate Director
Sure, I can respond directly to that. The onboarding process for immunization registries is not nearly as complicated as the onboarding process for electronic file reporting. There's a lot more validation that has to be done, which is what I think Seth was referring to. There still is a process, though, and public health departments do still have limited resources for onboarding, even immunization registry providers. But I think contextually just keeping in mind, though, that we do have a little bit of time to solve some of this. Because this year it's just that the Medicare incented payers who have to do this and by the time we get around to the providers that immunizations really care about the following year. I think we can really start to think about how HIEs could really help and maybe do some translation services from a CSV to a 2.3.1 message, which from a modular standpoint could still meet meaningful use requirements.

Hunt Blair – OVHA – Deputy Director
This may be a dumb question, but aren't there any adult vaccinations?

Seth Foldy – Wisconsin – State Health Officer
There are. We are interested in flu shots.

James Daniels – Medical College of Wisconsin – Associate Director
It's just, from the state's perspective, if I have 200 providers who are coming to me wanting to onboard for immunization registries, 80 of them, or let's say more than half of them see large pediatric populations, I'm going to prioritize those as opposed to the ones that just have adult practices. In some states the consent that's required for adult immunizations is more complicated than the consent that's required for pediatric vaccinations. As Seth said, the laws generally allow for the collection, but don't make it mandatory for you to submit it and that's for the pediatrics. Once you get into the adult, it almost always just allows for collection and usually with consent, whereas for pediatric it's much easier.

Hunt Blair – OVHA – Deputy Director
Now, to the point that you raised earlier, Jim, about work flow and to the question of what needs to happen now to support bi-directional use in stage three I think that it would be worth us making a comment. I don't think we can solve this now, but funding for the states is this just will never happen if there's not funding to support the public health agencies making these upgrades. We are in the fortunate position because the Vermont legislature, in their infinite wisdom mandated reporting prior to all of this and now that there are starting to be electronic systems besides Web-based systems we're catching up with what the law requires. We're small enough that it's not that complicated, but I don't see other states being able to do that. So, I think that that's really important. Then the other piece of this is on the certification side ensuring that the EHRs are capable of consuming the data back, which is not just in this context, but in others, obviously, it's a big issue.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there other thoughts and comments on this? Doug.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Let me just echo what Hunt said. So, to me there are sort of three issues. One is to get to meaningful use people have to demonstrate that they are using information in a meaningful way, but there's also the certification piece. And what we need to; one of the reason that certification programs exist is so that we can have the capabilities that the providers will need to be able to meet meaningful use. So, I think it's appropriate to continue to push for standardization so that those features and those functions are available to the providers. If the states aren't ready and we need to have funds or other things to make that possible, if we don't push toward standardization for certification, when we're ready to do that, the providers won't have the tools necessary to be able to make the connections.

So, I think it's important for us to think about that from a certification perspective. The other thing is, and it's in here, basically, that says we don't want providers to be penalized if there's not a catcher to their pitch. And so, what that means is that if you do the test and you can generate it, but it doesn't connect because the person on the other end can't retrieve it you're still penalizing getting towards meaningful use. So, in a sense we can push towards making sure those standardized capabilities are available and then as the marketplace matures and we get more resources to have the catchers get that information it should then be able to turn over a lot more quickly than if we wait until everybody is there to make the handshake.

Hunt Blair – OVHA – Deputy Director
And nothing I said was meant to inhibit the need to certify EHRs to send the appropriate message.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, one thought on this; it sounds to me, Seth, you and perhaps Jim Daniels have already sort of put together some very specific language related to clarifying this. I wonder if it would be helpful for us to see that and as a Workgroup take that, because this feels like it's pretty rough, the language we're looking at here. But you tell me; I mean, we can sort of take this any way we want, but if feels like there's something that's been more well digested from your perspective that might be a better starting point for us.

James Daniels – Medical College of Wisconsin – Associate Director
We focused more on electronic lab reporting right now, but it really is very similar issues and I think the clarifications will be similar so we'll start right into that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, and does that make sense to people, rather than trying; because it feels like we're dealing with something that already the public health community has moved beyond and are making some recommendations about.

Deven McGraw – Center for Democracy & Technology – Director
I think we can just put weight behind that by saying there seems to be a lot of ambiguity in the language that needs to be clarified moving forward and would rely on the advice of folks in the public health community to do that. Then maybe raise this issue about general concerns about the infrastructure and support for that as being the real rate limiting step that we can't control through meaningful use.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, Steve.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Yes, just the general premise, I think you'll capture this that clearly it's the hope and aspiration to get here. If it's possible and the EMR will do it, it's expected that it be done, but that the exclusion that if it can't be received or you can't get data from the IIS then clearly the provider is exempted so that they're not penalized for something they can't do. But you captured that, just to make sure that's in there clearly.

Seth Foldy – Wisconsin – State Health Officer
Yes. Now, have the mechanics of that been worked out, just going down a separate path, of the exemption, an exemption, like how do you actually represent, sorry?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It would be somehow in the attestation screens.

M
For Medicare this year it's definitely in the attestation screens. For Medicaid and send in payments it'll be through the Medicaid program.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm sorry, did someone else, David?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I'm just trying to distill what I've heard from this conversation, which isn't totally clear to me. Going to the second point in the stage three, the return data, about the reminders and status of the immunization registry, what I'm trying to avoid is that we end up being in a kind of a static mode because we're waiting for more public health agencies to be more capable of playing their part. And I'm just thinking out loud about whether there's some other way to test the EHR platform with a third party and have a third party reference test site or something, which could document or maybe even begin the process of substituting for a regional or state registry as a way of driving behavior at the provider side.

James Daniels – Medical College of Wisconsin – Associate Director
For the bi-directionality piece?

David Lansky – Pacific Business Group on Health – President & CEO
For the capability, yeah.

James Daniels – Medical College of Wisconsin – Associate Director

I think the vendors are really struggling with that piece as well so starting it sooner rather than later would be great. There are probably some of the Beacon communities and Challenge Grants, well, maybe not Challenge Grants, but maybe the SHARP Grants that are trying to do this in their work and I don't know, maybe letting them work out some of the technical details first.

David Lansky – Pacific Business Group on Health – President & CEO
The immunization registry community led by the CDC office, if I'm not mistaken, has convened an expert panel that includes vendors and others to look at the mechanics of this, but what I don't know is how far along they are and exactly which of alternate technical solutions they might recommend.

M
Is there a chance that we could propose that for stage three, at least hint this through the Meaningful Use Group, that there be some kind of a CDC-based reference site that supports the two-way transfer of data and so that meaningful users can at least by stage three have that functionality proven?

James Daniels – Medical College of Wisconsin – Associate Director
I think you're right. There would have to be a standard to support that. Otherwise it would just be impossible.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The other thing is, you know, this stage three will be in 2013, 2014 there will be a new rule I assume that defines the actual metrics for stage three. This was here in the meaningful use stage two regulations would be more reference points, but I expect that there will be a third rule that defines stage three meaningful use standards or metrics. Then at that point there will be the opportunity to look at that and reference it specifically or, actually, pulling out the results of that work that Seth mentioned for bi-directional communication.

Seth Foldy – Wisconsin – State Health Officer
We're still at the stage of foreshadowing our intent.

David Lansky – Pacific Business Group on Health – President & CEO
I'm kind of putting down a marker. I guess I'm disappointed that we're going to have started the conversation in 2009 and now we're talking about 2015 looking at that stage three box. If we haven't moved this functionality in six years and we're still having committees thinking what the right approach is we should find some way to set a signal through our various mechanisms to get this done by 2015, at least so that the standards are clear and the infrastructure is directionally correct.

M
I guess that's what I was trying to get at with the comment about the funding, going back to the very opening of the meeting, if part of all this is supporting health reform then we need to think systemically about HHS resources and how they're directed to move this all forward.

M
So the CDC process I'm referring to will conclude long before 2015.

M
So, just to your point, David, I don't think I'm hearing anyone saying that we don't want this to work and to advance and move forward, but if it's about making sure that the EHRs can exchange the data, in certification you can require that. You can use a dummy site at CDC. I guess what my reluctance is that I think it would not be appropriate to use the meaningful use program as a lever on the provider community because there's insufficient funding at the state level or county level for registries to do this. I mean that's a discussion way outside the purview I think of any providers to impact directly.

So, I don't think the meaningful use program is the right lever to help states get more robust in their ability to participate, but I think certification could require that the EMR be able to exchange with some dummy site set up so that the capacity is there. If a doctor is using an EMR they're going to record all their stuff

in EMR, so the immunization history will be there just awaiting the ability for someone to receive the transmission if you require the EMR to have that ability.

M
And the ability to process the return data that says this kid has missed the following shots and on the next visit this is the protocol.

M
Right, but I don't think through MU you can require any more than the clinician attempt to exchange the information with —

M
So, that would be the argument for leaving it, I'll call it, under-specified, but specified just enough to trigger the certification requirements that are already sort of in place, but no more than that.

M
Unfortunately, I think so, because this program can't push it much past that.

Seth Foldy – Wisconsin – State Health Officer
To make sure that we agree, it's directionally in the right place, so that we've got the standards and we've got everything kind of set up the way that we'd like to, once those other funds and resources become available.

Deven McGraw – Center for Democracy & Technology – Director
Especially if we come back to these topics this summer, I think it can be a really powerful role for this group to say, progress in this area is good, but there are some things we need to tackle. We're worried about progress in this area and it's for a set of reasons that we don't really have control over, but here's our worry and put that out there as a call to action that scopes well beyond what our ability is to handle it within an MU context. So, Steve's comments may not be the best or only way to do that, but I think that's well within our scope as we look back at these things to say, these three areas we need some real thinking. We would love for states and HHS and everyone to come together and figure out what are we going to do to move this ball so we're not having the same conversation again in six months. I think we can communicate that here, but we'll have other ways to communicate that over the next six months.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, I agree. So, Jim, do you have another point or should we just move?

James Daniels – Medical College of Wisconsin – Associate Director
I just want to say I think within a couple of years some states will definitely be ready to do this. There's a lot of really interesting work going on right now for the bi-directionality and if it would be useful to this group, that's maybe something we could put together as a short summary or presentation on some of those practices where that's going on so we know what's happening.

Seth Foldy – Wisconsin – State Health Officer
But I think, perhaps even more importantly I believe there will be a consensus on an approach that will be developed well before a couple of years that people are looking at the implementations that are going on now and at the public health requirements and clinical requirements for this exchange very actively now. The handicap is that neither Jim nor I are directly plugged into that group. You cannot take our ignorance as a statement of where the public health project is on this and I do agree that we should give you a follow-up presentation in the near future.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, that sounds great. I would suggest looking forward, we've got syndromic surveillance reporting, the public health button and ELR. Maybe we can think about syndromic surveillance and ELR sort of in one conversation.

Deven McGraw – Center for Democracy & Technology – Director
And public health button is a new idea, so we may want to defer that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Public health button, yes. Rather than reading through all of this; so on slide 28 we have the syndromic surveillance, which is pretty parsimonious here. It basically says move to core, that's it. The issues to consider are that it's not anticipated to be a huge implementation challenge across reporting, but, right, because this is only a hospital requirement, no? It's both, okay. So, no standards for the ambulatory, so maybe we should pause and talk about this one for a second.

Seth Foldy – Wisconsin – State Health Officer
I think we are hearing some concerns from the vendor community about the absence of a unified implementation guideline for this. A draft implementation guideline for hospital emergency room and acute care syndromic surveillance reporting is undergoing clearance for public comment in the very near future and there has also been some interest in the work of the ambulatory provider implementation guide, but work on that has not yet borne fruit. So, you do have the issue that there is not a clear-cut implementation guide. This need not, by our way of thinking, prohibit providers that do submit this information currently using 2.3.1 or 2.5.1 to the satisfaction of their local public health authority or state public health authority of attesting to same. But there is not a great deal of standardization out there for the vendor community to build to.

By stage two we anticipate that the implementation guide for syndromic surveillance from hospitals would be commented and final. A question, and this is a question, it is not a recommendation on my part, is the extent to which that guide be mandated in regulation. And I think it might be preferable in some ways to look at the response of the industry in considering that issue.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, it seems like we have one question on principle almost is can we really move something to core if there are no requirements out there?

M
There are no requirements for what?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Standards.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
There is a standard; what there isn't is an implementation specification is what it's called, but there is one written already.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, only for hospital, so not for ambulatory and this is moving it to core.

Seth Foldy – Wisconsin – State Health Officer
And one option might be to make ambulatory remain optional ad not core.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Peter, can I put you on the spot and ask you if you have any thoughts on this?

Peter DeVault – Epic Systems – Project Manager
I won't be able to offer a whole lot. This is not an area that I have a lot of expertise in. But, generally speaking, when there aren't standards yet it makes sense to keep it optional, rather than trying to develop the standards as part of the meaningful use requirements process.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, and hope that they converge perfectly.

Seth Foldy – Wisconsin – State Health Officer
Jim has been reading feedback on these recommendations by the committee. I don't know if he has feedback from the public health community on them.

James Daniels – Medical College of Wisconsin – Associate Director
Oh, sure. It's basically really what we've said, it's the lack of standards, especially on the ambulatory side, that it really doesn't make sense to move this to core for ambulatory when there's really no guidelines. A lot of people have called out the use of this type of data from an ambulatory standpoint, but there's no scientific evidence that it's really useful from an ambulatory setting. Then, for the hospital-based really looking for the specific implementation guides. I think everyone knows that ISDS has put out the minimum data set, but they're really looking for that implementation guide so that it can be standardized.

M
I mean if there's not science of consensus that it's even a good thing to have it from the ambulatory setting, maybe we should haven't it in the ambulatory setting.

James Daniels – Medical College of Wisconsin – Associate Director
I'm just saying what the comments are; I'm not saying that as a personal statement, just to be clear.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Walter, Jim.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I just wanted to make a point. I want to make sure that we understand and we're distinguishing syndromic surveillance from the traditional DC surveillance systems. It might be helpful because I think—

James Daniels – Medical College of Wisconsin – Associate Director
I think there is a lot of confusion, so syndromic surveillance historically has been hospital emergency departments submitting to public health a minimum set of data from every ED visit that happens. That includes the free text chief complaint, then basic demographic information about the patient, age, some sort of residence or geographic information and if they have discharge status, things like that. It's not a lot of data. The health departments have been very good at taking this data and using various statistical methods to actually convert those free text chief complaints and they really are free text. It's whatever you can type into those fields. Using statistical methods or just looking for key words, you know, changing those into syndromes and using these to look for unusual clusters of disease.

The idea started really around detecting bioterrorism events. It's turned out to be especially useful, it turns, to detect flu season. It's the earliest indicator of influenza. So, that's really all syndromic surveillance; that's what syndromic surveillance means to most public health departments is taking that free text chief complaint data and turning it into a syndrome and looking for temporal and spatial clusters of disease. As opposed to communicable disease reporting when it's an actual condition, which usually starts with a lab report that makes it reportable by law to the department of public health, like a test for Hepatitis A that comes back IGM positive. That's a communicable disease that's actually reportable to the health department.

So, for syndromic surveillance it's every ED visit; you don't filter them based on what they were seen for. It's just you send everything and then the health department actually looks for unusual clusters of disease, whereas communicable disease reporting is really based on a specific condition. It's usually a lab report that triggers it, although in some cases, like meningitis it gets reported before the lab test comes back because you want to start the interventions earlier.

M
It's kind of pre-diagnosis versus post-diagnosis.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
And one critical distinction, too, in syndromic surveillance the reporting happens every eight hours or up to 24 hours a day, so every day, every night, hospitals, emergency room departments send this feed back to the department of health. Disease surveillance it's more, of course, the patient was seen, labs were taken, labs came back, positive diagnosis of a condition and then it gets reported, the labs, whatever, 24 or 48 hours, or 72 hours, but whatever time. Now the part that is interesting about this, that's why it's so much hospital-driven because it's emergency room visit driven. The ambulatory aspect of it, it's an interesting one because it applies to a number of different types of visit now. So are we talking about ambulatory emergency sites or like urgent care centers, ambulatory care centers? Are we talking about going beyond that and any pediatric visit that shows up a kid with a fever or something like that, there's all sorts of implications when you're going to the ambulatory site for syndromic surveillance.

James Daniels – Medical College of Wisconsin – Associate Director
And I think that's why people brought up some of the scientific evidence lacking for ambulatory care data. When you look at syndromic surveillance you think about the behavior of the patient starting with maybe going to CVS and buying an over-the-counter drug and people do monitor activities like that, maybe missing school, those activities have been monitored as well. Then, maybe going to the ED and then, finally, visiting your doctor, getting an ICD-9 code three to five days after your visit that could actually be used for syndromic surveillance purposes. I think there might be some other ways of doing it, but those really need to be thought through before ambulatory is really going to make sense and that's what most of the comments have really been saying about ambulatory.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Jim Golden and then Hunt.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Yes, we've had a fair amount of discussion about this in our community and I think the biggest questions are what data, particularly when it is this broad and I think that then prompts the question of what level of data? I mean, how identified is that data? What standards will be used to move that along?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are you speaking to the ambulatory side now or just in general?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
In general; I think we don't do a lot of it, so we tend to have more concerns, I think, in our community. I think the other concern that I would raise, and I think it's more unique to this one, because particularly on the ambulatory side, the data that would be associated with this is ambiguous at best. It tends to raise a lot of concerns with the privacy advocates and there are people that actively believe that all of this exchange is really part of the government really getting their hands on your data. And to the degree that we have a term, that is syndromic surveillance, that particular raises their concerns and when they say what data, don't know; when they look at perhaps some of the stuff in here, it's not very well defined. It really in some ways hampers some of the other exchange efforts. So, to me, again, is this the right objective for the concerns that Jim has raised with some of the science on the ambulatory side, the ambiguity, the lack of standards and the degree to which it brings a whole bunch of attention in a way that is not what we're trying to accomplish? It seems to me that it is a barrier to exchange at large, for very little gain from our perspective.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Hold on just a second. Was that Seth? Seth, I'm going to put you in the queue right behind Hunt.

Hunt Blair – OVHA – Deputy Director
This is not scientific study, but I saw a presentation that Farzad in his old life and Neil Calman did about getting information on flu, exactly, like a week ahead of what they got from the hospital, but maybe others know more about that than I do.

Seth Foldy – Wisconsin – State Health Officer

First of all, the emerging implementation guideline; syndromic surveillance for that guideline is somewhat more de-identified than much information, name, address, that is to say street address and other highly personal identifiers are not included in the implementation guide. However, there has been a reference in the guide to including some kind of hospital person identifier so that if an issue of concern were to arise, public health might be able to alert the hospital, that the hospital, or the provider, might want to follow up with somebody. In other words, so identification of individuals is not a primary part of syndromic surveillance and, indeed most of the agencies performing the surveillance prefer not to get the highly identifiable data.

So, that gives it a different status than, for example, named case reporting of mandated reportable diseases. This information has been used for a variety of emergency-related functions. Another important use is, for example, we have bio watch sensors that sniff for terrorism agents in our communities that occasionally go off from time to time. Syndromic surveillance has been used to monitor to see if there's any rise in syndromes that might be coincident with such agents and thus to reassure the public, although sensitivity for that is not well-established because we haven't had an event. And it has been used for a variety of other health behavior monitoring that's been useful, for example, rapid glances at the changes in prescription use behavior and disease incidence after public health interventions, like if you move smoking out of public places are people using more nicotine patches and are they experiencing less acute COPD and heart disease. So, there is a growing body of evidence that this can help inform better public health application and policy.

Deven McGraw – Center for Democracy & Technology – Director
I just wanted to actually make that same point. In some ways this measure is part of a much bigger class of things we might want to do over time, which is to use electronic data to report counts of things that are going to matter, especially where what you care about is the delta. You don't care about who it is. You even can tolerate differences in definition. You want to look at the trend. So, I think what's interesting about the thing that Farzad was doing in New York is what they were trying to do is allow for local hospital definition of influenza-like illness and just report the counts of how many you had today. And what they found is it was the exact same trend you would find by reporting patient level data and they discovered it earlier.

So, I think that the meta question, not for this, but as we move to a future world, what we want to be using electronic information to be discovering things about population health, but not necessarily needing to report forward for all those kinds of things, individual data. I honestly haven't tracked where that initiative distributed has been, or whether it's now EHR-enabled, I don't think it was a that time. But I think there's a meta question here that's really interesting. I'm not sure, and so one question is to what extent can we use stage two? I mean, obviously, quality reporting that occurs for meaningful use could also serve that purpose. It's main goal is to show that you're improving quality, but you could also say we know that we have this level of diabetes control in the population.

The challenge with that kind of measurement is you can't deduce. So there are things where if you really wanted to know what your level of diabetes control is, you probably couldn't do it. But if you're simply looking at deltas over time this is a really good reporting mechanism to do that, so it is a really interesting question and one I think we should come back to at some point to discuss. I'm not honestly sure that I know or maybe if others know the state of play of that kind of stuff to know if it would be reasonable to require ambulatory guides to report flu-like illness using that kind of an approach or if that would be valuable or if we're ready for that. But I don't want to lose that bigger question or issue that I think we should all be working towards.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess—and, Steve, I'll turn it to you in a second—I personally feel some discomfort with moving to core the ambulatory requirement. I even feel discomfort with having the ambulatory requirement as a menu set in stage one based on what I've just heard, but that said—and I guess I also have somewhat of a concern of moving the hospital to a core. Except to the extent that if there are hospitals who are already doing it and can at least be able to check off the box on one of their public health requirements, then that's a good thing. Given that there are no standards, so presumably the way they check off the box is

just they're doing it and someone gives them the green light that they're doing it according to whatever the local standard is. So, I don't know how others feel about that.

Seth Foldy – Wisconsin – State Health Officer
And I think what you're describing now is currently in place for stage one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It's hospital only and it's no standards and it's menu set. Both, right. How do people feel about the ambulatory? Does anyone want to make an argument for moving the ambulatory to core?

Seth Foldy – Wisconsin – State Health Officer
Make an argument for it?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
For it. No, okay.

M
Find out whether any ambulatory or EPs have chosen that as the thing to check off on their list.

James Daniels – Medical College of Wisconsin – Associate Director
They've called states asking for it.

Seth Foldy – Wisconsin – State Health Officer
Remember, there are ambulatory practices. The problem with optionality is what it means depends a lot on what other things are optional and what other things are mandatory. So, in this case the ambulatory options are immunization registry and syndromic surveillance. Many ambulatory practices find syndromic surveillance to look the less intimidating of the two.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The other question is whether the syndromic surveillance system actually received data from the ambulatory side, if it's only the emergency departments at this point.

Seth Foldy – Wisconsin – State Health Officer
Certainly in many settings, for example, large integrated health networks, you tend to get a combined flow.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. So, on ambulatory it seems like there's general agreement here that moving it to core seems premature, that the infrastructure is not in place for that. What about the inpatient, yeah, the eligible hospital side?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, I think I would have no problem with the hospital moving it to core if the stage two is clarified. Because right now it says move to core, and then in proposed stage three it says mandatory test. So, what does it mean to be moved to core? Does it mean mandatory tests automatically? It seems to me that it means that. By moving it to core it means you have to do a mandatory test.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So, it affects stage three the same as stage two is what you're saying.

M
Yes, we were confused by that as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Well, given that the implementation guide is under development, is that even premature on the hospital side? Steve, and then Doug.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Just a positive thing. I think there was an example that I was told a number of years ago right here in the D.C. area where one of the hospitals, GW or whatever, had surveillance data that there was a spike in diarrhea illnesses and when they tracked it down by zip code it was a defective sewer system. And does that sound reasonable, Claudia? And because they could link it to zip code they found it was a sewer and they were worried is there a pathogen, is there a terrorist thing or whatever, and it turns out it was a bad sewer and they were able to get it fixed. So, there is value to this and as a member of the provider community as long as the EMR can take the work that I create and automatically report it, if it's set up and someone can receive it, I think the provider community, personally, wouldn't have a big dog in that fight.

I think the privacy groups and then consumers, and then whether the public health community even has the ability to receive and process that massive data, I think those communities would have the biggest discussions. So, core or not core, I guess the bigger issue, from a provider perspective, is just if the technology will automate it and if it can be done I don't think we particularly care if it exports our ICD-9 codes associated with the zip code or something. But if the public health community can't accept it or if the technology won't automate it, then I'd raise my hand vigorously and say, please we need an exclusion because we shouldn't, again, the same old thing. But there are really cool implications if we get to these things, but I think the cool implications may fall outside of the whole MU program because it's really next tier iterative benefit.

M
Right, but based on those criteria it sounds to me like a high level, that ambulatory might fall on one side of that whereas hospital might fall on the other side. But there are a lot of public health departments who are already receiving this type of data, so they're prepared to receive it and perhaps more, the systems and the processes are in place in many places to do it, whereas on the ambulatory side it's much more wide open right now.

Deven McGraw – Center for Democracy & Technology – Director
But that, to me, argues for something to remain in the category of optionality versus core. Because listening to this I'm like, was I not listening to the public health conversations in meaningful use because I don't think that the meaningful use program is the place to create public health policy, but it is the place to support public health policy that is enacted either at the federal or the state level. So, if there is a reporting infrastructure in the state, so that gets to the can they receive it, are they doing something with it versus we're just randomly sending people data because meaningful use told us to.

Seth Foldy – Wisconsin – State Health Officer
I think we can provide some reassurance to that can't; although it's not a highly standardized practice in the past it is a very common one. In fact, there are several states that mandate syndromic surveillance reporting today by law by providers and, obviously, our hope will be that these various local and state and regional variations will start to collapse toward more standardized practice to facilitate serving the data on behalf of the vendors. So, there is also the opposite side, which is right now there are both requirements and willing providers that are doing this fairly broadly, but it's a highly unstandardized practice and that's another reason why meaningful use might be, in a sense, called into play.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Doug?

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
I always try to make a distinction between satisfying the requirements of meaningful use and the certification piece of it as well. So, I think one thing that probably—and I've made a note of here as well—is I know that ICS has been working on developing a new implementation specification, but it is at this point relatively green and not well tested. We said it before, standards are standards because people use them not because we say they are. So it's important to recognize that if we want to advocate for a particular standard it's much better if we've de-bugged it out there and we know that it's actually working. So I think that's a conversation that, perhaps, this group isn't going to solve, but I think the HIT Standards

Committee will need to be able to say whether or not this is something that has sufficiently robust and well-tested standards to be able to support the meaningful use criteria. And they may come back and say it's not there; we need to think about revising the expectations.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well, it sounds to me like I'm hearing that most, if not all of the group, feels that neither of these should be moved to core for stage two. Is that fair? Is there anyone who feels differently?

Seth Foldy – Wisconsin – State Health Officer
Just with the caveat I mentioned before; sometimes leaving something an option when there are no other options, there's some logic to be worked out there, but I would not object strongly.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
The same comment I had on the last item. It's fine for us to provide input about the substance of the merits of the recommendations as a meaningful use matter and the appropriateness of the meaningful use program just as informed citizens. But the question of whether the Information Exchange infrastructure will down the road support the opportunities this type of data presents is one I'm not sure I have much clarity about. It was a little clearer in the sense of the two-way communication around immunization is, what the application, the support application was; in this I don't know that there's a two-way requirement. We haven't talked about that at all and so really all we have, as Steve said, is sort of this passive surveillance environment where we push out a lot of data to the wizards and algorithms out there and they do whatever they do with it and we're done as providers. If that's the end of the story then the Information Exchange burden and infrastructure requirements seem like they're very minor as long as we can certify products to output the data and at some point public health agencies know what to do with it, in which case it's almost off our table.

M
Seth did say there were some programs and hospitals where they were using pseudonymised data to re-identify if necessary or something. I thought I heard him say that.

Seth Foldy – Wisconsin – State Health Officer
Well, basically where the public health agency could suggest to the hospital that they look at number blah, blah, blah in the hospital system for follow-up, yes. But how often that occurs, I don't know. I guess I would say I'm not sure how comfortable I am about the issue of menu versus core for hospitals. I prefer to do a little more consultation with my community. I just wanted to say I'm not sure exactly how comfortable I am with that as a conclusion.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, why don't we note that as one of the follow-up items as we document this and, again, we'll be discussing this over the next couple of weeks as well. I'm sorry, yes?

James Daniels – Medical College of Wisconsin – Associate Director
The comments we've received so far were overwhelmingly about the ambulatory not being moved to core. A lot of people actually expressed support for moving hospital to core, as Seth said. The standards that ISDS has put out for hospital-based really are based on a long history of people submitting that data so the minimum data set, it's pretty well defined, the HL-7 implementation guide of that I think will be green, but the data that public health collects from emergency departments is fairly straightforward and well defined.

Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability
Just one other thing and maybe it goes to a parking lot for later, these items are sort of a subset of a much larger class of data aggregation and feedback, population health management tools. These are the most concrete and ones we have experience with in the last ten years, but as we think about ACOs and other population-based aggregators I just hope somewhere in here we're having a cycle where we think about the data infrastructure for aggregation and feedback in a learning health system. Which may not

be operationalized in these particular examples very well and we may be missing the forest for these trees.

Seth Foldy – Wisconsin – State Health Officer
Actually you raise an important point because certainly public health has wrestled with whether or not it wants to deal with syndromic surveillance as an aggregate versus near real time event-driven tool, but given its use to detect near real time events. Also occasionally to detect events that we didn't know we were going to have to look for, there's been a fairly clear identification of this data stream as needing to be discrete and event-driven and near real time.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
But I guess to your point right now the only owner of population health is really public health right now, but it may be that there are new owners with ACOs or something that are going to be important.

Deven McGraw – Center for Democracy & Technology – Director
That might be a good topic to put on our summertime, even a hearing.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
What we did on our summer vacation list, yeah. So, okay, well, let's move to the electronic lab reporting, if that's okay with everyone. So, this one similar to the previous ones, the stage one final rule is submitting reportable lab data. This is just a hospital requirement in stage one and it's now—all right, so in hospital, move stage one to core. So we've got it moving to core rather than menu set and then for the eligible professionals— I'll just read directly what it says here, "Lab reporting menu: For EPs ensure that reportable lab results and conditions are submitted to public health agencies either directly or through their performing labs if accepted and as required by law." Then we have this ambiguous language, "mandatory test in stage three." Then for the hospital, "Include complete contact information in 30% of EH reports," so we have a threshold there. And then for eligible professionals I think it's the same language as form stage two, which is basically making them accountable for their lab reporting data on their behalf, which seems to me to be sort of a significant new wrinkle in this.

Where prior, you could have the labs doing the reporting, but now it's saying the eligible professional is responsible for ensuring that their lab is doing their reporting on their behalf. The issues that we'd noted as no current capacity for eligible professionals to report, that right now information for the EP is being reported by the labs and a few states can currently accept 2.5.1 messages, which is the standard for sending this type of information.

So, Steve?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
The question, I guess, for the public health folks, if the labs are reporting this, all you want is the data, you don't really care who it comes from as long as you have it. Is it better to leave it that the hospital lab or the community lab is the one who reports the data to comply? How does it currently work?

James Daniels – Medical College of Wisconsin – Associate Director
Those are most of the comments that we received on this as well that this would be duplicative information, the hospital labs are already required to report. The one piece where it could potentially be beneficial would be from the national labs that aren't required under meaningful use to report to public health departments. Most health departments are getting it from them through some other mechanism, but it would allos for another way to get data from the Quest and the LabCorp and those types of labs to public health, to get it through the provider as opposed to from the national lab, which there isn't a requirement for.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
How does the law work – I'm sorry to do a back and forth – but how does the law work that the hospital labs must report, but the national labs don't?

James Daniels – Medical College of Wisconsin – Associate Director
So, sorry; meaningful use only applies to the hospital labs. If a state has a law it generally applies to the national labs as well. So, not every state has a law requiring electronic reporting, though, so that's where it could potentially be helpful, but the vast majority of the comments that I reviewed really got at the point that we're getting this anyway from the labs. It's really not necessary to get it from eligible providers. What's good to get from eligible providers is the additional clinical and epidemiological information that might reside in an EMR that doesn't reside in the laboratory information system. For example, if there's a positive STD test the EMR probably has their treatment status and pregnancy status, which is extremely useful. So, that probably gets more into the public health button functionality, not really ELR, but I think that most of the comments said exactly what you're saying.

Seth Foldy – Wisconsin – State Health Officer
So, if I could provide a little historical and practical context. First of all, this is driven, of course, by state and local law because the police powers of public health live at that level, in case you're wondering why public health always appears so dysfunctional, that is the reason. Now, that being said, in most jurisdictions the reporting is required of providers, because those laws were written before there were laboratories. Then when it was recognized that providers weren't reporting and that laboratories were a good source of information laboratories were added, so in many ways laboratories are reporting, in part, because public health has recognized providers tend not to be very good reporters. But, as Jim has mentioned, an electronic laboratory report or an electronic disease report does tend to be the beginning of an iterative, back and forth communication between public health and the provider an iterative back and forth communication between Public health and the provider. So none of these things are simple, but we largely concur with the language that we see here—first of all, moving it increasingly to core and bringing it on as menu for providers. But it is true that there is a fork in the road as to whether or not you allow a provider to delegate this task to the laboratory.

One of the things that is important about electronic and manual reportable condition reporting is that very often we get reports without patient address or patient jurisdiction, which means Public health spends a huge amount of time just figuring out who is supposed to manage the case and how to find them. So we're very strongly supportive of the new language for eligible hospitals. And where is that information going to come from? You will note that that information often is not in the laboratory information system. So I think we're starting down the right path by moving to a place where electronic reports arrive faster, and with less effort, and with more of the demographic information.

In the hospital setting it may make sense then to keep it coming from the hospital EHR. For providers, over time, that information is either going to have—for example, the address and jurisdiction (municipality) may need to move from the provider EHR to the lab, or the information is going to have to be added back, or the lab information is going to have to come from the provider.

I hope I haven't confused issues too much, but we like, very much, the trend that we're seeing here. It's very practical from getting the work of Public health done timely for the public.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. I guess we'll have Walter and then Peter. I would just point out that it seems a little odd to me that the Federal Government, with the meaningful use program, feels that it doesn't have leverage over the national labs, but that imposing this on individual physicians—somehow they're going to have leverage over the national labs. That feels like a real disconnect to me. Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. A couple of comments on this one. First of all, I think if we're moving to stage one core for hospitals, it seems like, again, this one is one where mandatory tests need to be brought into it as well. Because it's not clear in this table whether by moving it to core it means then that you're required to do it, or if you're required to do a mandatory test first. The second thing is, this is clearly—and maybe this just emphasizes some of the points that we made, but this is clearly an exchange between the EHR that has incorporated the lab results into the EHR— a message generated by the EHR to Public health. The

hospital lab is not sending the data to the Public health agency. It is the EHR of the hospital that received the data from the lab, or exchanged it, or has it on the EHR that sent the data to the Public health agency.

So my suggestion was going to be if we, in a previous measure, were looking at incorporating lab results into the EHR—and we were talking about 40% and we even started to move it up. Then move up the structured data incorporated into the lab—it seems to me that by virtue of that, the expectation is that the EHR in a physician side will have the data of the lab reported, including reportable conditions. So they will be able to generate and push out the data to Public health. So I think my suggestion is, we should tie this particular requirement of lab reporting from the EHR on Public health conditions to the lab requirement noted already that requires providers to receive lab results and incorporate them electronically or incorporate them into structured data in the EHR. So I think this creates a disconnect if we think that the hospitals are not going to be able to do it or the providers are not going to be able to do it, if we are already required to do it anyway from the lab side from the other measure. So I'm thinking we should clearly move this to core, which should put some— probably even consider looking at, again, mandatory testing of this. And I totally agree. I think the expectation that the EP would then become the vehicle to go to the lab and say to the lab, "You should send this to Public health," should not be there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So you're saying you agree with the EH, not with the EP?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I agree with the EH on moving to core with the mandatory testing and agree to bring in the EP as a menu option, but not require the EP to ensure that the labs submit the data on their behalf.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
I do have some response when you're ready.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO Well hold on, Sid. I've got two people in the queue here. So let me just turn to them, and we'll come back to you. Peter?

Peter DeVault – Epic Systems – Project Manager
Yes. I've got a few thoughts, and I apologize if they're not completely as connected as they were when I first put up my tent card. On the one hand, it started off seeming like if we needed anything it was perhaps uniformity in state and local laws about all laboratories reporting communicable diseases, which sounds like a good in itself, but not something that meaningful use would have much say about. It also seems the way that's worded—a strange thing to say that it's a meaningful use of an EHR system for a hospital administration to make sure that the laboratory information system is reporting, or that the community laboratory system is reporting communicable diseases that's not using any EHR at all. Maybe, as Walter suggests, what really needs to happen because there's data in the EHR's that's useful for this kind of reporting is that we stop requiring it of the laboratories but require it of the providers and the hospitals. But it seems like a longer term kind of thing to do, if today's laws are all about the laboratories reporting results. I potentially have some of my facts that I've gleaned from the conversation wrong.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. So this is on hospitals though.

Peter DeVault – Epic Systems – Project Manager
It's both.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I'm sorry. Well, hospitals as opposed to independent labs.

M
… are generally aimed at laboratories but the meaningful use is eligible hospitals.

Peter DeVault – Epic Systems – Project Manager
Right

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right

Peter DeVault – Epic Systems – Project Manager
And because that's the case, it seems weird that we would suggest that as a meaningful use of an EMR system, it's okay for you to just make sure that your laboratory reports that data. That's not really a use of the EMR system at all.

M
But I think some of those laboratory systems have been certified to do this.

M
Exactly.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
I would like to speak directly to that last find that there's something Walter was saying. It has become common practice and acceptable, as I understand it to ONC, for the laboratory information system that a hospital is engaging with to become certified as part of the EHR to send reportable information. So it is not always a process outlined that the information has to be imported in a structured way into the EHR and then sent to Public health. But indeed, it may be sent directly from certified LIS that the hospital is using as part of their EHR. So that's an important distinction.

And the reason it's important is—and also I think it's important to know that some hospitals use national labs as their labs. And, not surprisingly, national labs are starting to look at the question of how they might send information electronically on behalf of their hospital customers if they are certified. I don't know exactly how strong that movement is.

That being said, when we get to all of the doctors of the nation, the tens of thousands of players out there, they largely use a modest number of large lab providers. Public health could seek to obtain information from tens of thousands of small businesses with small EHR systems, or Public health could seek to create connections with a relatively small number of very large laboratory providers who provide services to all of those doctors. And I think you can see where the latter might be very attractive.

Now that being said, it is an optionality here that, as proposed in stage two, says, "EPs must provide directly or through their performing labs." I think it would be our hope that large labs would develop the capacity to send information efficiently to Public health on behalf of their clinician contractors.

M
….

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
I guess I didn't quite hear that comment. But it did remind me that many of the national labs are already reporting, and therefore, this would again enable us to reward good performance established in the past on behalf of clinicians.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Peter, did you have another point?

Peter DeVault – Epic Systems – Project Manager
No. I just forgot to put my tent card down.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Doug?

Doug Fridsma – ONC – Acting Director, Office of Standards and Interoperability
Thanks. I just want to sort of echo the comment that Walter had made about the standards around laboratory information being received or transmitted from electronic health record systems or from hospitals. We have right now two standards out there that are fairly common. One is the HL-7251 that really does a broad range of things. It's a very broad standard that has lots of different options and can support a lot of different use cases. And in California, there's a standard called e-links, which is much more targeted and doesn't have all of that information.

I think one of the things that we're doing within the SNI framework and trying to get some consensus on is, is there an appropriate middle ground that provides a sufficient amount of specificity. Which is one of the strengths, I think, of the e-links standard because it's quite clear about what the value sets are and what is mandatory, and when you need to do other kinds of reporting—not just reporting labs back to an EHR. So for example, including the contact information is a relevant thing because a lot of times interactions between labs give you an order number or an order requisite number, and there's no identifiable information about patient address, phone number, or the like, which makes it difficult for the lab then to do the reporting. There's another transaction that has to occur; you have to get that information before you can send it. So I think there is a value in trying to make sure that the standard for laboratory reporting and the standard for ELR kind of merge, and that we have a single consistent standard that satisfies the 80-20 rule. That will make it easy for the providers to do reporting or the labs to do the reporting because they have the information that they need.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there other thoughts on this? It sounds like on the hospital one, moving stage one to core—does anyone feel uncomfortable with that one? Okay. That seems like it's a pretty easy one. The eligible professional issue. Yes. Steve.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I guess for some of the discussion—which has been interesting for distancing me on the Public health things—I find myself scratching my head because there's important benefits and things we want to try to do, but I find that we're almost trying to solve some of these other bigger issues through this meaningful use program. And I don't think that that's a good connection. So for this instance, I think if you were just looking systemically, what would be the most efficient way to get the information? I think that whoever made the point about trying to get a relatively small number of large providers (i.e. labs, hospitals and national labs) to provide the information to the necessary Public health agency and, if necessary, then to require that the eligible provider—just to use our parlance here—is actually providing the appropriate information. So if you need name, address, and things like that, that you just say, "Well if you're going to submit certain tests, you have to provide…

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
A lab order requirement.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Yes, a lab order requirement. But that would be a discussion for a different setting because this program couldn't address it. So I'm not saying it's not technologically feasible—it's as feasible as anything else. It's just data in a set. So I guess I don't really, again, feel that we as a provider community have a whole lot of stake in this. I think the consumer groups may have a stake in it for what they do or don't want shared, and how that jives with state laws or national laws. But I know it seems less efficient to require all these little—this cottage industry of providers to share all of this than it does to have a smaller subset of really big providers.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Now as written, it says that first off it's a menu set, and second, that the eligible professional would have a choice. First a choice of whether to choose it, second the choice of whether to provide it directly from their own EHR, or to ensure that their lab is doing it on their behalf.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
… I guess is what makes sense for the overall system. So if you put it in as a choice and now you've got 10% or 15% of providers picking that choice, and 85% not because it makes more sense to do the immunization element. And that's actually more valuable because there is no other way to get that data. It seems to me that what we put in our menu of choices has the potential to drive behavior, and are we driving behavior somewhere that at the end of the day is counterproductive from a better way to do it.

M
But here I probably need to insert that with the future scope, fortunately, we probably should be looking at a lot more point of service lab testing so that Chlamydia, gonorrhea, and other tests that might be done in the office will need to be reported and might not necessarily be reported through the laboratory provider.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
… test, and they may be required as part of that to report that data because they're the actual lab that provided it then right?

M
That's what I'm thinking.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Right. So that's a different way to catch that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Okay. So sounds like we still have an open issue then on the eligible professional. Sid, you're going to resolve this for us.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Very quickly, I'm just going to open it up even further. We have language here about either direct or through the laboratory. What about through an intermediary like an HIE? Should we open up that language a little bit?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Good question.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
And this would actually serve the eligible providers if there were an intermediary being able to link across these infrastructural services that we've alluded to in order to fill in the gaps or make it easier. Just an idea that maybe we're too restrictive in the use of the word direct.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Jim?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
To address that, I'm not sure that you would actually have to put it in the language because for some of the other Public health options, the functionality is being met through the HIE. It's just up to the provider to certify that part of their functionality is being met through the HIE. So this certainly doesn't preclude them from doing that through an HIE. I don't think it has to be called out

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. That would be called direct as long as they attested that that was their technologies doing.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I think the point is—and maybe this was made long ago—is that particularly for the independent eligible providers, having these intermediate services may be something we want to promote.

W

That would be a good discussion.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Have to call ….

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Right, so I'm not sure I'll go that far, but I will say that I don't think you'll find any objections from public health agencies in working with HIE entities to obtain data. It sometimes simplifies things from our end.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
One quick comment I just noticed too on stage three. Not only are the lab reportable lab results required, but it also inserts, "and reportable conditions." And I think that is an important distinction in the following sense. Right now we're talking about reporting lab results to public health where there is a clear requirement to report them because it's a reportable condition, but that the lab result doesn't include the other clinical information necessarily that might be reported or needed for the syndromic surveillance. But at the end, we're moving toward expanding that, in my reading, to not just include lab results as the reportable element, but also reportable conditions and data on reportable conditions that might not be lab result related.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that's in stage two too.

Seth Foldy – Wisconsin – State Health Officer
It is in stage two, and I wasn't going to just stay silent and let that slip past the group. We too noticed that and think it's very important.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
According to stage two too, yes.

Seth Foldy – Wisconsin – State Health Officer
Exactly, and obviously in stage two we would probably want to make sure that it referred specifically to reporting of non-laboratory information that was already supported by good—at minimum—test implementations, because it could potentially refer to a fairly large number of types of issues. Fortunately there are some good test implementations of certain types of non-laboratory public health condition reports that are mandated by law. But, again, this will require some very close attention to which ones we're referring to and how to make it explicit.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. So I would suggest we recommend clearly distinguishing and probably even separating the two because at the end, public health will benefit from receiving a report from the provider of a patient that has a reportable condition. And in that report the provider includes not just the lab results, but the clinical information that will be valuable to do the c-surveillance needed. So I think that is not very clear, particularly considering the fact that this is under the electronic lab reporting requirement of meaningful use. We use in this particular slide "Communicable Disease Reporting (ELR)", but in meaningful use the specific requirement here is lab reporting to public health. And so I think we might want to clarify the scope and distinguish the two components—the lab results themselves as well as the clinical information— which the lab will not have. The provider has. And since this is expected to come from the electronic health record then the provider will be expected to provide that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's a very interesting point.

M
And that would also allow us to uncouple them in terms of which ones are core versus menu, and the stage in which they are applied. So there may be some other arguments for that as well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Although, it may be that that takes away the option of an eligible provider being able to delegate the whole thing to the lab because the lab isn't going to have the conditions. And if they're just responsible for the conditions, are there standards around that, requirements around that? Seems like that could be a big open question. But, Jim Daniels and then Peter.

James Daniels – Medical College of Wisconsin – Associate Director
Alright thanks. I think what Walter said and Seth followed up with was empathized in the comment for this one a lot as well in that condition reporting in the clinical and epidemiological information that you're getting really overlaps a lot with that public health button function. And that actually might be a nice way to separate them from stage two and stage three—to just keep the electronic lab reporting in the stage two, and the other information really as part of that public health button that's more of a stage three. There's nothing in stage two for that one. Those are some of the comments that brought together just exactly what you said that I saw. Although personally, I would beg to not merge the concepts yet given the lack of clarity on public health button and what it means. Again ….

Seth Foldy – Wisconsin – State Health Officer
Well, I think that that might be what it means, that's an interpretation of what it means.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
But to your point, it still might make sense to separate—let's say stage two lab recording, and conditions as stage three. Peter.

Peter DeVault – Epic Systems – Project Manager
… and another thing to recommend it—if we're keeping track of things that recommend this—is that with the lab reporting we were talking about a contained, and it sounded like, universal set of data that we always report with these: name, address, and the lab result itself. Whereas with conditions, as Walter was starting to talk through that, it was clear that depending on the condition, there are probably relevant pieces of clinical information that would have to go with that. And that's a much more complicated thing to try to do.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. So it sounds like at a minimum there seems to be some support for saying that conditions ought to be taken out of stage two because of the complexity of that. At a minimum, I would say I think we still have the question, which I think, Steve, that you were uncomfortable leaving the EP section in there at all. I would just ask what your thoughts are on that.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I just think it's uncertain or unclear enough that it might be premature, at least at stage two.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. We can note that as part of the documentation here, and then take that off the … as we look at the written results of this in the follow-up. Okay. We're actually, if we eliminate about half of the ones that we're going to do, we're right on time.

M
Are we talking about public health button?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Well I thought, so I guess we have a question. For any of the new ones, which would be starting with—there's a list of care team members, record a …and care plan, patients can view and download

information, an electronic copy of discharge instructions, exchange data with PHRs, and then the public health button are generally new.

M
…

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. There's nothing in stage two for that, so I might suggest that we try to address those over the phone. But given that we're actually on time with the original schedule, and we don't need as much time at the end for the qualified entity, I think the medication list and med reconciliation is a very important one that we should definitely take up. And then maybe we can take a quick break, and then move to the quality reporting and the rest of the agenda if that makes sense to people.

So we're on slide 21, which is page 11 of your written—she's here. Okay.. so

Allen Taylor – ONC – Public Health Analyst
I apologize but I'll have to sign off, but I thank you very much for letting me participate during this segment.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Sure. Okay there are two pieces to this. One is maintaining an active med list where the threshold was 80%. That was stage one. And then the other is to perform med reconciliation as a menu set item 50% of the time. And the proposed stage two for the active med list was to continue the stage one. So keeping it. I guess it's already a core, and keeping it at the same threshold.

Then the proposed stage three is 80% of medication lists are up to date. Arguably that's kind of an extension of continuing, but perhaps exercising a little more diligence over them. The comment there was to expect the drive list to be up to date via medication reconciliation. So I guess it's starting to recognize that med reconciliation will provide a way of keeping that active med list more robust and up to date. The medication reconciliation is 50% threshold, but it's a menu site item right now. The proposed stage two is that it be conducted at 80% of transitions by the receiving provider, transitions from another setting of care, or from another provider of care, or the provider believed it was relevant. Does it stay as a menu set? Or does it move to CORE? Medication reconciliation conducted at 80% of transitions.

M
Oh no. That's a core.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO.
Sorry? It stays menu. Okay. So it stays menu but the threshold goes up to 80%, if I'm reading it right. There's a lot of words there, but it seems like it's just moving from 50% to 80%.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I know Allen's gone, but maybe Devin knows this. Has there been a statement about what number—a bunch of the menu have moved to core. so what number of menu items…

Deven McGraw – Center for Democracy & Technology – Director
Off the top of my head I don't know. A lot of them. That does not help.

W
Are moving to core?

Deven McGraw – Center for Democracy & Technology – Director
Yes, and so then I wonder if you're still. So that might be—that'll become relevant as we think about..

Claudia Williams – ONC – Acting Director, Office State & Community Programs

I think it's a really good question to have a scorecard. I know from some of the comments that I've seen from members of the public, largely the trade associations who follow our work closely, is that there's a desire not to go much farther than making some or all of the menu options core and leaving the standards set as they are. But I'm actually not aware that anybody's even done a scorecard. It used to be 15 core and 10 menu. And now it's 25…

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So we've got a little bit of that here.

W
We just did it for the ones we care about.

W
Right. They were cherry picked.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think it's helpful to sort of see the overall burden and where the scale tips. I think it's a really good idea. I wish I had an answer. I just gave you a really long winded non-answer. Allen probably could have told us like this, but he's gone.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Just out of the list here, the only, maybe you can correct me on this, the only current menu measure that will stay menu is this one: medication reconciliation. Everything else that is menu will move to core. Now there will be new measures that are being considered as menu. But new ones like the one we talked about just a minute ago—EP reporting to public health. It's kind of making it a menu option, but so far in the list basically this is the only one that is … a menu option and stays menu.

W
Yes. But this are a cherry picked selection of the whole matrix. It's not the whole matrix.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Oh no. I'm not looking at the list here. I'm looking, actually, at the publication from the meaningful use work group—he whole list of all the measures. And I looked at that, and the only one that is today a menu that stays menu is this one: medication. Medication reconciliation …
Lead man

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Do you recall what the … because it is interesting.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I look at all the other ones that ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Because it is interesting, it jumps from 50 to 80% and then to 90%, but it stays as menu the whole time.

W
It stays as menu. My recollection is that this one is still considered to be a really tough one to get done. So while there's this strong desire to push as hard as possible, there's still the idea that you could fall very short of the percentages that you would need to meet—what allows you to count it as menu and still get your payment. That's my overwhelming impression is that, again, that we need to get a lot of comments on just how hard it is to do this. Just how much is involved in terms—not the technology so much as work flow—that there still needs to be the option to not have this be required.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I have a couple of comments—one on the meta-issue of moving things from menu to core, and then things specifically about med reconciliation. It's occurring to me with all of these things moving to core—

and I didn't realize it was quite as severe as it sounds like it might be—that many of the menu items are moving to core. We will have a lot of organizations, providers, and hospitals who, when they try to meet stage two, won't have had any experience with the measures in stage one that are now core. And I wonder whether the right solution, since we are trying to stage people—that's the name of the game, right? We're trying to stage people into these things—whether instead of moving things to core we just say in stage two, "Now you have to pick more things from the menu than you had to pick before." And maybe the numbers are moved up a little bit, rather than saying, "Now you have to do something that you didn't have any experience with in stage one.

W
I don't love all the children equally, and so I just personally—thinking about things like lab results. I'm just thinking about the things that are truly just the foundation for a bunch of other stuff. So that would be one option that would provide nice flexibility and allow folks to do what's available to them. But in messaging these were also messaging the whole set of other people involved. So it will create changes from labs; it'll create changes from vendors. So part of what we're trying to do is put pressure on the providers to do stuff. But honestly, we're also messaging the world that we need ways to do this faster and cheaper and better, so…

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That makes a lot of sense, but with the sheer numbers of things that are…

W
Sure. No, no, no. I think we have to weigh those too. I guess this one, the thing that I think is so essential, is knowing accurately what meds your patient is on and making better decisions based on them is so foundational. And I agree this is hard to do, we don't have great pull to do it. But it feels like it's one where we have to make really good progress…

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
And those comments weren't specifically on this item at all.

W
Yes. So...

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
And specifically on this item what I'm wondering is—they're all kind of the same thing, but I think people think of them as two different kinds of med reconciliation. Within the hospital the Joint Commission requires that every time there is a change in level of care, from ED, to observation, or ICU to medsurge, or whatever it is, that you do a med reconciliation. And that's so that the new care team understands these meds were supposed to be stopped when they moved to the ICU, and these are the new ICU meds when we change them out, which is different than changing care settings in a lot of peoples' minds. Which is really the HIE aspect of this.

So when the patient gets admitted, during the reconciliation of their home meds with the new orders that the doctor wants them on, or when they get discharged, telling them to stop taking the meds that they were on from their PCP and start taking these new ones. And I'm wondering whether these numbers reflect both of those kinds of transitions, or if this is just the HIE type of transitions—because it's absolutely difficult. And ever since Joint Commission, it's been difficult for hospital providers and nurses etc. to do med reconciliation at every transition of care. It's a different set of difficulties to do those at the transition of care settings. And that might affect where we want those numbers to be.

Deven McGraw – Center for Democracy & Technology – Director
There was an enormous time spent on this particular issue, but I cant's recreate all the dialog that went back and forth. And I just suggest that the questions that get surfaced by this group be communicated because, maybe, there is something that's been spotted that didn't get thought about and that was standing a lot of discussion. It's on the phone, it's not always with ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Steve.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
First of all I couldn't agree more with Claudia that this is a uniquely important thing that hopefully technology is going to make more possible for us to do. I also could not agree more that in present day reality, it is incredibly complex—very, very difficult because patients don't know what they're on a lot of times. It's hard enough for people with M.D.s and Ph.D.s to try to sort out what they're on, let alone the average person who's just a smart individual—let alone the average person who doesn't have all the education. So it's very tough. They get things from multiple pharmacies, multiple doctors. We have multi-source collection of data, which is difficult.

Then the other thing that's challenging—and this came up when the joint commission was requiring medication reconciliation across a lot of different settings. It was a huge mess because they were requiring it across all settings including ambulatory settings like the emergency department, where the pace at which we work. The very problem focused nature of the care we provide for the vast majority of patients just make it another impossibility. So if you're taking care of someone for an ankle sprain, it is really utterly irrelevant. It's not that it's unimportant—but irrelevant for us to delve into someone's whole medication history. And it's also beyond the ability or the training or the scope of someone in my setting to try to reconcile someone's five hypertension medications. So then that raises the other issue when you go to a specialist. So if you're seeing a urologist or you're seeing an ophthalmologist or you're seeing a dermatologist, they don't have the knowledge—they just don't—to reconcile your diabetes medicines and you hypertension medicines.

Now if in the world of an integrated health IT environment they come into your office, and the EMR pulls down a medication list and a big old warning comes up, "You shouldn't be on these two medicines. Fatal interaction." I think they have an obligation to alert the patient, "You need to stop these medications and get immediately to your regular doctor." But other than that, it's just not even reasonable. It's kind of like asking your auto mechanic to give you an opinion on your heating and air conditioning system in your house. They're both different types of mechanics, but it's just not going to work. So it's important, but I think at most it would remain on the menu. But I'm not even sure the menu's the right—it draws attention to it. But I'm struggling because the goal should be at all the critical transitions, which may be better defined.

So when you go into the hospital it should definitely be done there. When you go to the ICU, it should definitely be done there. If you go to a rehab facility, it should definitely be done there. When you're discharged from wherever to your primary care physician—when you show up for your first post-hospital visit, it should probably definitely be done there. So there are certain settings where it should definitely be done, and it is within the scope and purview of the professionals doing it.

So I think we have to be very careful though because the Joint Commission created a huge nightmare of mess across the country when the ways we were trying to comply with this was like when we had to give antibiotics for pneumonia within four hours. High potency, broad spectrum antibiotics were given to anybody with a cough in the waiting room because they knew the average time to see the doctor was two and a half or three hours in some of these inner city hospitals. So the only way they could comply was just have a candy jar and say, "Take a pill, and when we get to you in five hours, we will have fulfilled the obligation that", but we're breeding resistance at the same time. But we met the requirement for CMS,"

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
And maybe not everybody realizes this, med reconciliation doesn't just mean knowing what meds that patient is on at transitions of care, it means making a determination about each medication on the list and whether they still should be taking it. I don't know that everybody understands that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Doug?

Doug Fridsma – ONC – Acting Director, Office of Standards and Interoperability
So when I worked at the VA hospital, every transition of care you made cancelled all of the existing medications, and we issued them. And you still had to ask the patient in terms of doing medication reconciliation because they'd go home and they had this whole pile of pills. And they wouldn't be sure whether or not they should continue to take those old ones or the new ones that they've got or whatever. So I think medication reconciliation is incredibly important. I don't think, however, our goal here is to create an automatic medication reconciliation. Because quite frankly, what the patient takes and what's prescribed for them are often times very, very different. And if we really are talking about a safety issue, you're going to have—to whether you like it or not—interact with the patient, and find out what they actually are taking.

The question though in my mind around this one is, "What are the functions or the features that we would like to enable that would make that medication reconciliation easier or faster or more accurate?" So do we need to have—where do PHRs fit into this? Are clearing houses a way in which this can be enabled? What are the kinds of standards that we would need? Obviously, if there are 16 different drug formularies, we're not going to be able to highlight that there are two drugs within the same class or that are similar because we've got so many different formularies to deal with. So, to me the question isn't whether or not we should do medication reconciliation—because obviously we should. And whether we have electronic health records to help us or not, good doctors need to do that if they're involved in the continuity of care—all the EHR things notwithstanding.

But the question I have is, what about meaningful use and electronic health records and the standards and certification process can be used as a tool to help make that reconciliation process easier, better, faster, cheaper, safer. And so to me in some sense—perform medication reconciliation 50%? No, we mean we should strive for 100%. But the question is what do we want to enable that will make it easier for us to get to 50% or to get to that 100%.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Go ahead Paul, and then Claudia, and then David and Walter. Go ahead, Paul.

Paul Egerman – Software Entrepreneur
My comment is that these are all very important comments, but this is the information exchange work group. So to me the issue is, "How does information exchange impact medication reconciliation?" And I don't see that it does right now, directly, except to the extent that we said that there might be electronic transition of care documents transmitted.

But I don't think beyond that, that you can do much more electronically doing reconciliation. And I see on this slide, there's this comment about the fill history or compliance data. And my observation on that is, unfortunately, retail pharmacies are just terrible at that stuff. They're terrible at giving you compliance data; they're actually even worse at using it. If you cancel a medication and send them the cancellation, they won't do anything with it. And so the problem is the retail pharmacies are outside the reach of ONC as far as I can see. So I look at this and I don't see how with information exchange we could do anything to directly impact it. I mean we can do it indirectly—see how patients have access to the record through the portal. That might help. But I don't see how we're directly impacting it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
This is one where I feel like we're in the same place we were when we were thinking about stage one. And that's frustrating because it is so important. At the same time, it's where we are. I guess I'm really trying to think about—really, what we want is decisions around meds to avoid errors. We want to improve adherence. We want to allow for cheaper options that help patients. So if we can even think of it in terms of the things we want to change or enable for a doctor—this is really all just serving that. Right?

So I think there has been a fair amount of experimentation. I'm thinking about the work that Marc Overhage has done, and I high about how to take the … med list and how to make it really decision friendly. I think there've been good practices around how you talk to patients about their meds and get them over the feeling of—and actually get useful information from them. So I think there's a bunch of stuff going on out there that's trying to work on this problem. But it doesn't feel congealed enough that we can—it's always hardest to do meaningful use requirements when there's not a clear sense of the care process we need that then needs to match the technology.

And I feel like here we're in the middle of trying to innovate the right care processes to get to things like adherence and to get to things like knowing how to use med lists that might be electronic. And there are big problems with—people say, "Well that data's not accurate." But at the same time I feel like we can't let ourselves off the hook. We've got to make a ton of progress on this in the next year or two so that we have the tools we need to be able to get to these goals that are so important. So I'm feeling a little frustrated that we have nothing better to offer in the way of meaningful use requirements.

And maybe these are the right ones, but they are subject to a bunch of questions and problems. But I'm just wondering if as we get to our conversations this summer—and I think there are important exchange pieces around—I know the Challenge Grant in North Carolina is talking about, "How could you create some kind of shared care plan—a shared med list that folks could annotate and share each other's insights about the meds?" Because the problem is too, that you're having ten docs all doing the same med reconciliation. There's no way to say, "I already did it for this list."

So think of the poor patient who has 20 doctors. They're going through it 20 times with every separate doctor, and there's no way to authoritatively say, "This list has already been cleared up. Here it is." So I think there's a lot of shared care process issues that are imbedded in this that we haven't really tackled. So I would just want to use caution, I think this is the stuff we had in stage one. It may still be exactly the right stuff, but is there anything more that we could think about that would add more momentum to where we really need to go.

Doug Fridsma – ONC – Acting Director, Office of Standards and Interoperability
If I can just comment—once someone has done an authoritative medication reconciliation, all I need to know from then on is the delta. What got added? What got subtracted? What dose changed? That's all you really need to know. And if you keep maintaining that delta every time a transaction occurs—what that delta is—one would hope that you have a fairly robust medication list. You don't have to necessarily reconcile it each time. You still have to ask about it over the counter and things like that, but once you've got an authoritative one, you just need to know the transaction deltas in some sense.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So we don't really have a clear cut way to communicate that either in the standards or in the care processes. Right?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We've established that that's sort of the truth and then …

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Right … you can still doubt it and do it again if you doubt me because you think 'm not a good doctor but ….

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Walter, Peter, then Steve.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
David actually went before me.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Oh, I'm sorry Dave. You're thing isn't up.

David Lansky – Pacific Business Group on Health – President & CEO
I'm going the same direction as Paul and Claudia. And again my theme of the day is "What does this have to do with IE?" And I think the challenge, if we're speaking back to the meaningful use workgroup—we're taking this as the policy direction that has already been sketched. We want to support this. And the questions Paul's raising, I don't know what the right answer is—whether there are or are not important information exchange design requirements that we should be anticipating.

I think when I talk what I'm missing is a diagram that says, "Here are the contributors to the necessary data for med rec at different points in care and in care transitions. And here are the actions, like this delta business, that would be triggered by the aggregation of the relevant data. and then here's the propagation of that data across the network once it's been done." Those are a series of information exchange transactions that we need to understand and then say—the fear I have is that so much of the work we're doing so far in the program is around EHRs within a silo.

And we are at the moment where we get to think outside of the silo and say, "How do silos talk to each other and add value for care processes?" And I would like us to have a diagram that says, "Okay, there's the dispensing pharmacy. There's the PDM. There's multiple prescribers. There's the patient and their family at home (with their PHR hypothetically). There's the smart gadget at home—the mobile expensing gadget." There's all kinds of componentry here that together could be exchanging information to produce a better solution to this problem.

And if that's the scenario we have for the next five years, what do we need to be recommending now in terms of either incentive structures that move us there, or design features that go out to the state HIU programs, to say, "Hey, you better make sure you do X—barcode storage." There's something we need to manage, and we're not having that conversation. I think that's where we need to in this one—more than micromanaging whether it's 80% or 50%.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Which I think was probably Doug's point too. Yes, Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm in the same line of thinking from an IE perspective. I think going back to the questions on slide 14 that we always ask which is, "What exchange infrastructure is required to support the objective?" And I think the exchange—that's where we need to focus on is, "What is the exchange and whether that exchange exist?" "Does the required infrastructure currently exist or will it be available in stage two?" I'm not sure that it will. And that's why I think this particular measure should continue to be a menu option. And increasing it to 80%—first of all, I'm not sure how many people chose this particular one in their menu listing. Maybe zero of the current meaningful use applicants are going to say, "This is the menu option I want to do." Because who are they going to do it with?

The other point that I think is important to remember is that the requirement is on the receiving provider. This means that the provider that receives the referral or the transition of care is the one that needs to do the reconciliation of the medications. And so it creates a possibility of a pool scenario where the provider has to go out and seek—whether it's a PBM, or whether it's a pharmacy database or whether it's a HIE database saying, "I have this patient that got transitioned to me. I need to find the medications that they are on and pull that out" And I don't know that the infrastructure exists to do this.

So I think that the bottom line to me is this should continue to be a menu option. Increasing the threshold to 80% I'm sure is going to scare people more from it than anything else because there is no—unless they operate on an HIE that has already the capability, like maybe Indiana. The Indiana health information exchange has that ability, and providers say, "Oh. We can fulfill this 100% of the time." So I think this should be still important.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
… Peter?

Peter DeVault – Epic Systems – Project Manager
I have a proposal building on what Claudia and Paul and Walter have suggested. So we've already identified transitions of care where we want care summaries to be exchanged, and we've got a beautiful architecture for continuity of care documents that allows both human readable and machine readable information to be in them. We've got requirements that they have to include some of the machine readable data. Why don't' we also include—and we can decide what stage it belongs in, why don't we say, "Instead of trying to raise the bar on medication reconciliation as part of the HIE group? Why don't we say that as part of the medication reconciliation process for those transitions of care for which you are already required to get the continuity of care document, you must have a mechanism to consume the medications from that continuity of care document" Again, as part of that med reconciliation process. So it drives both the use cases for— it drives the usefulness actually of having those transitional care documents in support of the med reconciliation and moves us a little bit further.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So is that not a part of the requirement to be able to consume a CC ….

Peter DeVault – Epic Systems – Project Manager
Consume means, purely, to be able to show the human readable content within the EHR.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
… you have to have these structured forms also. Maybe those two things haven't been high …

Peter DeVault – Epic Systems – Project Manager
That's more of a production requirement than a consumption requirement. The consumption requirement ....

M
Did you hear what Claudia just said? I didn't hear that.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I just said that, remember there were those requirements around particular data fields which have to be structured.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Putting it in. So what Peter's saying is I can only have to consume it and …

Peter DeVault – Epic Systems – Project Manager
You have to store it in its complete form, but you don't have to do anything with the data other than render it on the screen. So what I'm suggesting is that maybe what we do is say that, in this stage or the next stage, you actually do have to be able to do something with it. You have to be able to pull in the medications on that document as part of the reconciliation process.

Paul Egerman – Software Entrepreneur
That's a good suggestion. But why are you limited to medications? What about problems?

Peter DeVault – Epic Systems – Project Manager r
That's a great point, but purely because of the context of the current discussion.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Okay so things that would help—and again, I'm biased by my setting. So if my health system implements an EMR, and the patient's registered, and they come in—if the EMR can automatically query Surescripts and obtain for me a med list—automated. That would be priceless.

W

… I thought anyone with a certified … scrubbing tool can obtain the med list from Surescripts? Is that—what's the problem?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
You can go down and you can pull it down. But it'd be it just was an automated process. If a person's registered it turns on ….

M
… requirement, and I get confused because of what we can actually do and what we are required to do. But I don't think it's a certification requirement to do anything other than to show that list of dispenses. I don't think you have to be able to say, "Add this to the current meds list."

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Yes. And so I guess I'm just saying—and it's probably because I'm in a world where I'm not using any of this wonderful technology this robustly yet—that would be priceless. So you don't have to even ask anybody, almost, anymore. You can discuss with them, educate, converse, but you don't have to go in and say, "What are you on?" "I'm on a pink sugar pill and the blue pressure pill.," and stuff. It's very confusing. And I don't remember, I used to know this better I think. But is this—it's not retail pharmacy fill data right, in Surescripts? Or is it?

M
Increasingly it's both.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
It didn't used to be as much right? Okay. Good. Because prescribing certainly doesn't equal fill, which is well documented. The other thing is it'd be nice if there were some way in this, and I don't know how you do this because I don't think the Surescripts network is designed to do this, but if you could capture when the last time a comprehensive med rec was done and by whom.
Because if the urologist sees that well they just saw their family doctor two weeks ago and there was a complete med rec done—that's one thing. Because I think what will happen is if the patient sees a cardiologist and an internist, and the internist— there's hundreds and hundreds of medications that we commonly use, and you become comfortable with certain ones, and so practice varies.

CMS knows this all too well that there's variation in healthcare delivery. But some of it is just because as human beings, you get comfortable with your repository of drugs you use, so there could be a reasonable conflict between a cardiologist and an internist, and both of them could be reasonably correct. But one wants you on this blood pressure pill and one wants you on this one. And so it would help to know when the last time was that someone reconciled that. So if you disagree, maybe you then can communicate with that other clinician and have a discussion for the benefit of the patient. And then the last thing is just to share with you, not a gripe about the software products but just a reality. It's going to have to get a little more mature, and I don't know Epic, I only know it's … or what I'm currently using.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I can tell you need a chart.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
But it presents for me normal saline flushes in a list with medications like powerful antiarrhythmic medications. So I'm looking through a list of things, and it shows things that were prescribed in 2008. So I have this jumbled list that takes a lot of human time to go through and slash through and circle what's current and what's old. And it carries things over one visit to the next, which is helpful if they're still on it but not helpful if you just quickly glance and think, "Oh they're already on an antibiotic." But in fact that antibiotic was from a year and a half ago. So the way the data's presented is not—it'll mature with time, but it's not yet in the form that for and end-user clinician makes my life easy. It's quite cumbersome. And I'm picking on my one bender, but it's very heterogeneous I think.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Sid?

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Yes. I guess I just want to follow up on that thought and ask, "To me, in terms of the health information exchange, I think the standard would not necessarily be for when was the last time that the medication list was reconciled, but rather, does the standard exist for medication meta-data about when that specific one was done?" Then we could take our decision support infrastructures and do something meaningful with it. So that could be a proposal maybe from this group that—well, I mean it's the same that Steve's talking about. If we knew when this specific medication was last reconciled, rather than— and if there was a standard way to message that across systems rather than have a clinical observation that medication reconciliation occurred thus. I'm just trying to think how we would do this.

M
There may be a way already or through an easy extension to the CCD spec.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
And that's what I'm thinking. And I know our group hasn't done that yet, but that's where my mind is going. And within this time frame I'm thinking we could either push that standard or do the demonstration of the usefulness of it, and make progress.

Paul Egerman – Software Entrepreneur
That last suggestion sounds very reasonable. I suspect in the timeframe for stage two, since you're talking about something that hasn't been done yet, it would be more of an issue of test bed or piloting or something first. So I'm not sure you'd be able to get it done for stage two, but it' very reasonable.

To get to Steve's comment about possibly using the Surescripts solution, it's also a good comment. I have no idea what Surescripts looks like but I for sometimes it's difficult something that may not have been designed for that purpose. I don't know what their system was designed for. I also suspect that there would be some privacy issues there. Even though you're talking about access from an emergency department, I just think there's a whole series of privacy and security issues with that kind of query/response system that we haven't looked at.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
That may be true. Our customers are … though. So somebody's worked through those issues already.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Or not.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I think would be helpful for our group to say, "Make comments on this stuff," but then say, "We think this is an area where we really need to push functionality—push usability." I don't know that we have a specific— but we need a way to share observations and metadata as we move patients. So I think one of the conversations we've been having at ONC is what would be the functionality needed for a shared care plan for a patient, and how would you record, "Hey. I'm managing this med. I'm managing this condition."

So there's sort of aegis's of management or control, and then there's, "I want to make an observation on something that you're—" So there's a whole set of interesting questions around— there's this future state. But I think meds are a great example of where we want to be able to almost share observations about the data with each other and meta-data about the data with each other. And I don't shifting that CCD across the transition is the most effective way to do that ultimately. But maybe that's where we start.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I was going down the same path. I guess I thought that I heard some more pointed things that might actually give us some very concrete things to work on—like Peter's idea about lining up where we are with respect to certification and the consumption of those CCDs as structured data. And I know I've seen it somewhere in the past, but I kind of forget, where consumption means consuming it as parsable data—

not just the meds, but in this case for meds. So that seems to be one concrete thing that we could offer. The other that strikes me is to Steve's point about, "What are the barriers to being able to get better data from Surescripts or … There are lots of issues there. In Massachusetts you only get a 60% hit rate because not all the payers participate in it. So you've got all of those issues that make it more or less usable for this. But to the extent that we're looking at e-prescribing in a variety of ways, that might be a way of us looking at what might be the barriers there and trying to ….

M
… situation scenario

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. From a function that is available today. It's available today, but it's not as good as people want it to be.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
What we're talking about now is having some kind of coherence to the set of things that we're talking about, rather than e-prescribing here, lab results there, public health reporting there. We've got sort of an ecosystem of capabilities that we're talking about now.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
The last thing I heard, which I don't think is necessarily—and then Paul I'll get to you in a second—is that it isn't necessarily information exchange, but is about the way the data is presented within the EHR itself.

But to the extent that we're talking about wanting to be able to have the EHR to have an ability not just to consume it as structured data but be able to do something with it that it presents in a way that's more amenable to med reconciliation than perhaps today. Now that, of course, relies on the data being better structured than it is now and all of those issues.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Two other points—one, I think some state law precludes Medicaid from releasing prescription data. I think that was different from state to state, at least it was when I—I think two years ago I was more up to speed on that specific thing. And then the other thing is—again, this is not the IE workgroups domain but the bigger issue—when we have 51 million uninsured people and all these folks on Medicaid, med rec is a real issue for over a third of the people in the country because they really don't have any medical home to reconcile anything.

All their care is episodic, and it's provided in emergency departments or provided because of EMTALA for free. So it's real problematic—a lot of these things that I know we can make better in some ways for a lot of people through technology. But the way it's going to be better is if we get data sources that come from real fill history. So if you're off the grid per se. You paid cash at the $4 list. I get a real fill history wherever you went from the actual fulfilling pharmacies. That would be the most useful source of data because it most realistically captures what's happening and doesn't rely on third party payers of others.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
All the people who aren't subject to meaningful use. Right? And was there another comment here? I know Paul and then Jim?

Paul Egerman – Software Entrepreneur
Yes, I was just going to say I really—the more I think about it, I really like—I guess it was Peter's idea of consuming the CCD for medications. I think that would be an incremental step forward from stage one, and it doesn't require any effort on the part of physicians. But they potentially could see some forward progress as a result.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. Okay. Jim?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
The comment I was going to make is actually related to Steve's. You know a lot of states have a system—that is really coming out of the criminal justice world—that has all pharmacies reporting their fills. And the downside is that varies state by state as to what they have and the accessibility of that. But a number of our providers have found that for select circumstances, it's a better data source for medication history.

And their challenge is still the reconciliation. It's still just a mess and a lot of work to actually get that sorted out. But that is another data source, and it's one that doesn't seem to be very well connected up to what we're doing on the health side. And so that might be something for us to explore as to whether or not that's a data source. It goes under a variety of names—NASPER, PERAC. Every state tends to give their system its own name as well.

W
… for the purpose of managing controlled substances?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
It's for controlled substances, but some states have actually gone much broader than that as well. And that also does pick up everybody that walks into a pharmacy and purchases something. And the other nice thing about that is it tends—in Minnesota, for example, it's uploaded daily. So it's much more real time.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
… false birthdates and social security numbers, and then it breaks down. But for the vast majority of people, it works very well.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
It does have some pretty significant, potentially chilling effects on health information. We're experiencing a little discussion about that right now in the state because we kind of want to keep the criminal justice system separate from the health information exchange.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
That would certainly be my preference. They do have different purposes, which does have an impact on the data elements that they're specifically collecting, if they're being careful about it. But many of them are not. It just becomes a bid data repository. And we were just talking about the one that got held hostage in the commonwealth of Virginia. States … prescription drug databases within the last two years. So it does matter when you sort of collect it all in the middle.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So to wrap up on this one, it sounds like the real issues for us, as the information exchange work group, are really more about recognizing that it's actually a very complicated process. And the process issues here are much more fundamental than anything that we might be able to say on 50% or 80% or 90% is the first thing I think I heard. The second is that I think we might have some specific areas to explore that would provide tools that would make that process better. And that could certainly be something that we could provide a little bit more perspective on—both in the near term, perhaps, leading up to April 5th, but certainly over the summer when Claudia plans our summer vacation, and we're able to dive down deeper in some of these things.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
You're not going.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So with that said, I would propose that we take those other ones, as I said, the new ones, and deal with those in our calls because those might just require a little bit more homework. And our best—not start a fresh year. So that means that we can now turn to the quality measures discussion, which I think David Lansky is going to lead us through.

David Lansky – Pacific Business Group on Health – President & CEO

I actually think we're not going to spend a lot of time on it now, although we can. But it's probably better as a precursor to the next agenda item on the qualified entity. But we'll see. So I think the premise of this which is … builds very well on the last conversation. The premise for this is the new generation of quality measures will require data that comes more than one source or more than one point in time. And I think our challenge is to anticipate if those new quality measures make it through the vetting process in the next year, and still are possible for stage three and maybe some for stage two. Do we have the information exchange capabilities in place to support these kinds of quality measure that would be used eventually for payment? So just to kind of refresh your memory on some of the ones that are in the stage two pipeline and maybe stage three as reality plays out.

So let me back up a step because you're not all as tuned in to the meaningful use ramifications of the process. But essentially, we have put out several sets of measures for discussion—ones that are retooled established quality measures that are not going to be very challenging. They're relatively risk re-specified for electronic versus paper capture.

There's a second set that fit into five categories of measures, which are being put out to contractors for refinement and specification. And that new set—many of them will require multi-data sourced elements to compute the quality measure. So for example, some measures are longitudinal outcome measures. Did a patient show a better functional outcome six months after a knee replacement? So we want to capture some data from the patient and then attach it to some data from the episode. Some might be readmission data. Did someone following one discharge get re-admitted to another discharge—maybe not even to the same facility?

So there you might imagine needing claims data to be mapped against the original clinical data to look at re-admission patterns. Similarly there's an ambulatory care-sensitive hospitalization measure. Somebody who has gone from primary care management and shown up in an emergency room with asthma—is that a failure in primary care? But it may be part of a reportable measure. How do we connect that admission for asthma to the primary care EHR da ta stream. So these all have information exchange ramifications of some kind or other. Once we know how to extract and match the data together, somebody has to be responsible for manipulating it. Does that data go back to the eligible professional or to the hospital? Or is there a third party, like an HIE or a vendor, who does the analytics and produces the quality measure. Medication measures, including across sites of care—so med reconciliation is going to be one.

Some of the calculations are, for example, brand-generic ratios. An efficiency measure based on generic utilization could require pooling data from multiple sources. Efficient use of diagnostic tests, for example, repeat imaging for lower back pain—if somebody has recently had the same test done, an imaging study—maybe want to count how often that happens as another efficiency measure.

We talked about re-admissions, clinical decision support use. Some of the quality measures may depend on actually implementing clinical decision support and reducing for, example inappropriate, prescribing. And patient reported outcome measures. So that's kind of a laundry list of things that are being considered. And here's a summary of some of the functionalities that are required to support some of those kinds of measures—computable data to support quality measurement, data availability as a point of measurement. This is more preventative than a policy question, "How do we make sure that EHRs don't become silos." And one opportunity is that the quality measurement strategy requires data integration. It means that the partners have to be sharing data with each other to some degree, or at least reporting data using common standards so somebody can do the measurement, and then linking patient's data across sites of care.

So I think for today all we really need to do is tee up this set of expectations that the policy process is generating, and ask ourselves, "Are we anticipating these in terms of information exchange requirements?" These are mostly going to go beyond the point-of-care clinical applications that we've been talking about all day—and talk about really extracting nuggets of data from multiple sites, mapping

them, and analyzing them. And this will become a pretty core requirement of the next generation of meaningful use. Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
I'm sort of listening with an ear to if we were going to go out to talk to …and … and our grandkids and say, "Hey guys, it's coming down the pike. What do we need to do?" I think there's a big set of capabilities around patient matching—data's coming from here; it's coming from there. How do you know it's the same patient? How do you link it together?

I think somewhere in here you're probably aggregating data at some point, and there's a lot of policy questions around where that's occurring. is that a voluntary—"I signed for XYZ quality aggregation entity. Is that at the state level? Is that CMS doing it? Are there ways to do this in a more distributive way using hashing?" So I think there's an assumption that somewhere along the way you have to pull the pieces together and know at a person level what it looks like. And I just think there's a ton of policy and technical questions for how to best do that.

One story to tell because I think some states are already moving this direction. So Maryland, as you all know, has a rate-setting commission that's very powerful … that sets hospital rates for every hospital in the state. And they've already said they want to ding folks for readmission—preventable readmission. So CRISP, the HIE entity that we have given a grant to, is indeed going to be using its EMPI and ADT seeds from hospital discharges, to seed a data stream around readmissions that would allow you to know that somebody got discharged from here and got readmitted here. And then they're still going to have to figure out which of those were deemed preventable.

So that data is going to start flowing to the rate-setting commission to then turn around to a payment ding that will go to the hospital. So some states are ahead of where we are, I think, at a national policy level and are already trying to figure out how to build that infrastructure and are asking all these same questions about technology. I just think that this kind of set of issues is one where we need the policy and the technical discussion to be very, very closely tied together because I don't think we have well thought out—and I might be wrong. I'm thinking maybe Vermont does. I think only in pockets have we had the deepness of conversation that gives us a governance structure to think about, in addition to the technical structure, how to do this.

Paul Egerman – Software Entrepreneur
On the very last bullet on the screen—being able to link patients' data across sites of care—basically, that's a process that the PCAST work group is going to be producing a report on in April that, at least in theory, will facilitate that through into stage three. And it's interesting what Claudia said about linking technology and policy together. So an issue that we have wrestling with that entire process is it does need to be linked very close together, and it's hard to figure out what comes first in that process.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Steve.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I have a question then I'll make the comment. The question is and since—I think, Deven—you're the sole surrogate for the consumer vantage in the room right now. But since I know it's such a homogeneous population that you can see we have, I'm just curious because this seems to be one of those areas when you start to do multi-source aggregation of data where I imagine there's some concern. I'd like to just know what your thoughts are from that vantage.

Then the comment—just because my blood pressure starts going up not specifically because of you Claudia but as you mentioned—that when I think about the "never events" and the preventable admissions; cutting the wrong leg off is clearly a never event. There are a lot of other events that are arguably not "never events" that are not necessarily always preventable. So as we do this, I guess, from an information exchange standpoint, I would beseech us to focus all of our effort on how can we best aggregate data to identify what is really happening in the delivery of care and the outcomes. But then try

to keep our part of this out of the discussion about the policy implications of what's done with the data, which will happen in other for a with CMS and Congress and all those.

So focus on, "How do we get the data where it needs to be", whether that be in payers hands, patient's hands, provider's hands, so we can steadily improve the quality, and then leave—and you weren't specific how. Because I just think about the preventable thing, and then it leads me to tell my stories that some of you have heard me tell at different settings about the people who call 911 two times a week and keep coming. And even calling the police on them doesn't get it to stop. And then someone will someday say that I don't get paid because they shouldn't have been re-admitted when, in fact, I've done every single thing I can, and there's nothing else I could do. So now it's just another unfunded mandate for doctors and hospitals to care for human beings that the rest of society says, "Well, we're not paying for it. So go for it." And so I think it's one of those raw nerves that touches on the doctors and hospitals after a while.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
And I would say in that Steve that we should make sure that the complete data picture is available, so there's contact for—to the extent that we can orchestrate information exchange capabilities. So the best possible decisions are made along the lines you're describing.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think if we know what really happens, then we can hold those providers who provide substandard care accountable for that. But then we can identify where an individual human being who, either through lack of ability or choosing or means, can't navigate the system as instructed, advised, and aided. Then we can identify where the real problems are. I think that would help us all at the end of the day.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
So to your earlier question, I'm going to put a couple of hats on here. So putting on my advocates' hat—we think about issues of secondary data analytics and how that gets done a fair amount and we're thinking about it more and more. And there is no sort of one way to do it, and there isn't even a consensus around what's the best way do it. But anecdotally what appears to be the path that's pursued, more often than not, is to create a separate database for the use or collection of uses or measures or analytic functions that you want to perform.

So whether it's collecting the state prescription drug data, all of it, dumping it regularly by data feed into a database for purposes of monitoring possible criminal behavior—whether it's creating another database of what might be the same data or different data for another purpose—more often than not we're duplicating data, creating a data feed, taking that data, and then analyzing it— and often for very laudable purposes. But the more often that you copy data in multiple places—we're ratcheting up the risk.

So putting on my regular consumer hat though, consumers are most comfortable when data stays where it's created. And more often than not they think about that in terms of their physicians and the hospitals who care for them. I think people generally understand that data gets created as a part of the treatment process, and data needs to be in the record and shared out of the record, but per the judgment of the people who created that record in the first place. And when you sort of copy that data into multiple other places—and for some people when that's government controlled—it adds another level of sensitivity, depending on who you are.

So advocate hat back on, we're trying to think about how do you do the kind of analytics that you want to do without always creating another database to do it. And there are some promising models out there, but it is like swimming upstream to promote them. Because everybody assumes that the way to get this done is not to take the data that exists and figure out a way to just reuse it without necessarily having it copied and put somewhere else, but to instead assume that you have to collect it. I'm still searching for some good evidence about when you need to create your own separate database. When you actually could use distributed research networks as a model—bring the question to the data—having people put their data in a common model to the extent that we're increasingly moving to greater standardization in health data that will help enormously. But we know we're not there yet.

So one of the projects that comes to me is the Sentinel Project from FDA, which is a distributed data analytic model in the Public health context, where the data holders do the analysis. They put their data in a common data model so that it's all commonly expressed—but the raw data doesn't get fed into a database for Harvard Pilgrim Healthcare, which is the mini-Sentinel pilot contractor for the FDA—for them to analyze it. They get the results and they get them collectively from all of the data partners. And then to the extent that additional data might be needed to confirm signals, there's a process in place for being able to do that. But that's on a discrete one-to-one basis versus just continually dumping the data in.

So I think as we think about measures that look at quality across different settings of care, I think it's important for us to be mindful of ways to do this that don't necessarily encourage or require the creation of a separate database in order to do it. Let's leverage the databases that we already have to the extent that we can. That was a long-winded answer, but you struck right on something that we've been thinking about and isn't really getting sufficient attention. Everybody just, "Oh we'll just create a data warehouse and have everybody give us the data. And then we'll run the queries on it."

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
… desire to go down a distributed federated data path takes you back to Paul's point about patient matching, and RLSs, and all kinds of other psychology and privacy issue that have their own loops within loops. Walter, you wish to comment?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes. I just wanted to make a couple of comments about this aspect. I think without going down the list one by one of each of the quality measures and see which ones directly—which might be an exercise that this group might need to do. But generally speaking, I think if I am going to be required to generate a measure to demonstrate meaningful use or to report that quality measure to an entity, depending on external connections or data from other parties and having to connect and having to try to pool data from other parties to be able to generate my own measure, would be very difficult. And I think there are sort of two concepts here that I think we're trying to merge, and maybe it's not working. One is measures I can generate because I have the data myself. It's the data about the patient—how I saw them and all that. Then there's kind of larger scope measures that look across a community at things like readmissions not within my system. I can look at my own readmissions in my own hospitals, but I cannot see the readmission of one of my patients in someone else's hospital and then that person going to a third hospital. That can only be done through a community measurement effort. And so I think we need to probably decouple the two and not expect that one entity will be able to report readmissions that go beyond its own system readmissions, and include readmissions into other systems. That would be hard to do.

So I generally think that any measure that creates that expectation of a community-wide view needs to be done by some external party, and not by the entity itself. Because basically, every entity that has some stake with that patient that went two or three places will be searching for the data on the other two places. And then the data will be reported in three different places. So I think there should be a decoupling of the measurement in terms of, "These are my measures, and then this is the community view of the measures." And you can. There are many communities that do that—look at how a particular group of providers do with respect to readmissions across systems.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I too wear a couple of hats. So let me just start by saying that I absolutely agree, with my health policy hat, on that it is important to look at care coordination and measure the healthcare delivery system as an integrated whole. And to the degree measures go down that, I fully think that's where we need to go. That having been said, I do want to echo Deven's point about the challenges—both on the technical side and where they run smack gob into the policy. So I think that thinking about how to deal with MPI on making sure that you have it. In Minnesota we have, from our own research, about 67% of our ambulatory clinics on—the CDC had us at about 80%. So even just having a complete data set in a federated sense—we're actually doing quite well with who we have connected. But by our own data we've only got two thirds of the actual sites—probably more if you count physicians.

So you have all sorts of those types of technical issues. But where we would have a giant problem looking at this is on the privacy front. So in Minnesota, if you want to take person identified data and move it from one provider to another, you have to have the patient's consent. If you want to give it to the government in order to aggregate, you're going to need statutory authority. And I doubt that you're going to easily get that in Minnesota today. If you want to give it to a private third party, and it's identified—for the most part, you're probably going to need the patient's consent; particularly when you start to aggregate. And so, again, you might get that. But you might not. And I think that unless you have some way of doing this that is more aligned with what Deven was saying, it's just going to be impossible from a policy front in certain states.

And the rationale for that is I think there are enough citizens who are concerned about where their data is flowing that they want to control that. And while I personally think that measuring the healthcare system is quite important, on their relative scale of importance compared to their personal privacy, it's not that important. And so I think there are going to be some very real challenges, particularly around privacy. I think some of the technical ones—there's a whole variety of those too—but I think others have probably raised those a little better than I could.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Anybody on the phone have any other comments on this one before we flow this into the larger question of HIE?

M
I just think it's a fascinating issue. It's fun to talk about it at this level. It's just a lot harder when you actually try to do something.

Deven McGraw – Center for Democracy & Technology – Director
… you know these issues of coordination across different workgroups come up all the time, and we try to just be aware of them. But here's an issue where you're having a really deep conversation about the right kind of measures of quality group, and kind of where is the right place to have the bigger conversation about measure. And there's a privacy piece to that, there's the what are our goals and objectives, there's the quality—I'm wondering just from a HIT policy—maybe that's the kind of issue that should just, frankly, be taken to the broader Policy Committee because it can't be parsed. There's a PCAST part to this—so to the extent it would be helpful to continue having a conversation about these same questions, I'm wondering what folk thoughts are about how to do that.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
You know, my sense on this is that in some ways this is an IT issue, but not really. I really think this is about kind of the core of health reform. And so if you want to think about how do we pay for value within the system—high quality, low cost—and we think about payment reform. If we're thinking about accountable care organizations or whatever the exact version of that looks like. I think you're going to have to then think about how we would hold an accountable care organization, or a collection of organizations, accountable for their collective service delivery. And it seems to me that this is a much bigger discussion than HIT.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
So here's what happens though—and Devin alluded to this—what happens often is folks are like, "Oh we have to measure this across this. So we'll do it this way the way we've always done it using IT." So IT often gets uses as the reason you have to do it a particular way—like centralize the data. So I totally agree with you that this is a much bigger issue. But for better for worse, our set of issues is often used as the wedge for why a particular path is the right one. And this is also an area, clearly, where we're ONC—just one little part of that whole conversation—even at HHS. It's a much bigger conversation, obviously, than just us. But I think that the early indicators of a direction often do come from the IT side.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division

I think conversely also, even in high tech, the scope of ONC is not restricted to the meaningful use metaprogram. And the HIT Policy Committee is not limited to the HIT incentive program—EHR kind of programs. So I think there's a challenge as we all look at the environment, and James, you described it perfectly. The world will be looking at this process we're undertaking to create the capabilities to do the measurement—to do the payment. All the other things that we think are important. And my concern is that our little workgroup here even though we, as tiny as we are, has to somehow be thinking about, "What can we do to put in place the infrastructure that'll allow the health reform program to go forward and do quality measurement, payment, whatever, and address the issues that we've just surfaced today." We've got to start that ball rolling basically now. That's our job. And it's a little bit of a stretch from where we started. The morning was a pretty granular look at these individual quality measures for stage two.

But if we don't do it, I don't know if anybody else is going to. And we could end up on the other hand being regarded, as you said Claudia, as the bottleneck. That is the reason why we can't do payment for episodes across the continuum because, "Well, can't exchange the information across the continuum. Too bad." Which is where we've been for, frankly, 15 years.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

I think, Claudia … and you guys have done this very well, I think, since the institution of all this use of these pocket groups—well Judy and others. But I mean to the extent that an issue—I mean the Policy Committee is ultimately the top body for this. So certainly it would be within their purview to do that—or to the extent that a single issue rises to a sufficient level, which if you're talking about society policy issues related to the larger public health use of data and information, then a new multifaceted workgroup, if there's a need—certainly we've had numerous of those. But people from this group and the Privacy and Security Group and whatever other ones were needed because to bring all of us together it's just too big of a group. So you'd have to do a subset and recompose a new group for sure.

Like the PCAST, one is a very time-limited and focused one, but it's very germane. Again, since we're transitioning to the bigger issue kind of discussion and some of the stuff that Jim kind of commented on, I agree with you. I think it really does touch on the larger health system thing. And one of the challenges—I think we turn to the health IT and HIE because it is a concrete and tangible and real lever that currently has a lot of attention. One of the frustrations I think I would have from my constituency side is the tool is becoming not the tool to enable something to happen, it's becoming kind of, "What do we want to have happen" and then, "How do we contort the tool to do it?" So it's not just enabling now; it's actually becoming the way to drive what healthcare looks like in some ways because the other things are so much harder to get at. And so it gets challenging. It does get challenging at times because then you get HIT getting into things like medical education and people's board certification, and how does it intertwine there. And you start to wonder what's supporting what? Medical education doesn't support health IT. Health IT should support medical education; a provision of healthcare.

And then the other thing you touched upon—ACOs and things. You see, my continued frustration is as a nation—health IT can provide fantastic things to help us. It really can, and I hope it will. But we've made societal decisions that we leave 50 million people out in the cold with no health insurance. So they functionally have no way—no financial indemnification to get care. And then we have the Medicaid program that underpays and is poorly coordinated because it doesn't provide a lot of resources for what it does—even though it consumes a lot of money. So I think it goes with the challenge that what we design here can be for the benefit of every American because every American will touch the health system at some point in time. But it overreaches by far that it will fix the cost things because those are bigger issues for a different place. And the American people have no consensus on that. And so I think we'll continue to be struggling with it even though we'll make great strides with what we're doing here that will help the provision of healthcare.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division

Yes. I absolutely agree with Steven on that. One of the things that I was thinking about though is one of the things that we've often thought about in my agency. Around any particular problem is the science of the problem, the operational feasibility of the problem, and the politics of the problem. And it needs to be really a three-legged stool that all are there and addressed appropriately. It seems to me in thinking

about some of these quality measures—there is the science. You need the medical community involved to think about those types of things. On the operational feasibility, David, I think you 're right. I think IT really needs to think about what it is we're going to bring to the table. How are we going to deal with unique patient identification? How are we going to ensure we have the right tools in place with the databases that we need and the like.

But when it comes to the politics, I don't believe that the IT stuff, from my involvement in both of those two pieces, is the driver. Nobody I know in Minnesota wants to change privacy laws because of HIT of just exchange of information. When they start talking about those things, what actually matters is unsustainable rising cost in healthcare—that, "My employer keeps cutting my benefit set and raising my premiums." That, "I'm not able to get care because I can't afford it." Those are the real drivers that are going to be changing something as substantial as patient privacy. So I do think that there has to be a concerted effort between the HIT high tech, HIT policy people are doing, and the types of infrastructures that are being placed and created under something like the ACA to really drive some of these other questions to Steven's point. And it has to be done in concert. So we can't be the bind in the system, we aren't going to solve that alone either.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So that was a great introduction to the next topic: qualified entity. Claudia?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
We've already really touched on this several times today. But the idea that was presented in the HIT—we wanted to sort of parse apart the concept of an HIE test, which I think this morning we kind of decided was probably not that productive right now—given some of the other measures we're looking at. But ask the question of whether we would like to have a nod toward the idea of using an entity to help you perform an information exchange function.

So I think as we think about the world over the next few years, I think there will be intermediaries doing a lot of different things, whether it's doing analytics or doing the kind of basic push exchange or doing query—there's likely to be, whether it's RIOs or whether it's church groups or whether it's at the EAFs under PCAST—I don't think we have to think of those as particular things exactly like what they are today. But I think the question we're trying to bring to this group is whether the concept of having an intermediary perform a function is something we think is a good idea. What kinds of scope might be attached to that? And then there are a ton of questions around what that means for certification, and how that would actually be implemented that I'm not sure we'll get to today.

And so I don't know, Mickey, if you had other— so I think we just want to open that door of conversation to say, "Good idea or not. What would this look like? What kinds of scope might be appropriate?" And then there are a lot of implementation questions. "Does this mean an HIE or whatever it would need to get certified with respect to that function?" Etc. etc.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. I would frame it just like you did Claudia. We've talked about them in a variety of different ways in different workgroups for different reasons and purposes. But we always seem to come back to this generic concept of intermediaries being useful for different things. And those are in different contexts. So again, not that we're going to decide anything here, but since it's come up over and over again in multiple ways, we thought it was a good thing to put on the table, and see if people had any thoughts on it that we wanted to weigh in on at this level—even as a workgroup.

Paul Egerman – Software Entrepreneur
I do have some comments. And what you're showing on your slide here is the list of things that could be achieved through what you call a qualified entity. And on the previous slide, it said you would use governance to look at—basically, it was like security and interoperability. And I guess the conditions of trust and interoperability—and a couple of questions or concerns. One is if being qualified just means interoperability in trust and security, that doesn't necessarily qualify somebody to do all those other things. It seems like you use the word qualified to imply that you could do lots of other functions as an

intermediary. But the requirements to become qualified are very limited around trust and interoperability. So that's one comment.

A second comment is, what about covered entities? What about large healthcare organizations who are currently doing all these things? Are they qualified entities also under this sort of governance process? I'm sort of confused how all of that works. Or perhaps it's an issue that nobody knows how it works.

Claudia Williams – ONC – Acting Director, Office State & Community Programs
And I think one thing that's hard about this discussion is we're trying to at least show the potential linkage to something else that we're not really prepared to—that's not what we're discussing today. So I think this idea came up in the Governance Workgroup that part of what governance might look like is some part of accreditation process for entities that meet certain benchmark requirements. So all that we're pointing out—we're not necessarily saying that that would cover all the things we wouldn't want to have looked at in deciding whether an entity could be deemed, but just that there's this important link between these two sets of ideas that would need to be looked at.

Paul Egerman – Software Entrepreneur
Well, and when governance—I assume that is about conditions of trust and interoperability. But that's not the same as saying that somebody's able to handle medications or do quality reporting. And that's an NW-HIN governance issue either. It's sort of like the linkage between the two. It sort of feels like we want to create a situation where these intermediaries will somehow receive some additional stature as being qualified, but I don't necessarily understand why that stature gives them the ability to do other things that are possibly required by meaningful use.

Deven McGraw – Center for Democracy & Technology – Director
Yes. I don't think I have an answer to Paul's question. I'm trying to grapple with what's the question on the table for us because certainly a covered entity can hire a business associate to perform any function on its behalf that it would like. At the end of the day though, the entity receiving the dollars from the meaningful use program is the covered entity. And so they're the ones who are going to have to attest under penalties of perjury that they have done all that they've been asked to do in order to—so if they want to rely on somebody else to perform a function for them, they can do that.

But the way that the law, I think, sets it out today is it's still the covered entity that's going to have to be the attestor for the payment. So are you suggesting that if there's an entity performing a function, whether you want to call it an intermediary, a business associate, whatever label we want to stick on it. If that entity meets the conditions of trust and interoperability established for NW-HIN governance, then that entity should be able to attest on your behalf, and CMS should take that? What's the objective? What's the problem we're trying to solve with this discussion? I mean, what's tricky here is we're actually also bringing up something that was—maybe we've framed it more broadly. But this is the proposal that was put forward by the MU workgroup in that one HIE test, in terms of allowing—if you do bi-directional exchange with an exchange, that should satisfy this requirement. We have framed it much more broadly. But I'd love to hear, not having been there, what the thinking was in that group about the benefit and value that—why was that put in there?

Claudia Williams – ONC – Acting Director, Office State & Community Programs
Well basically, that was put in there because in order to—the whole thing was framed in a way that would compass the types of exchange that we thought were likely to be going on in stage two, which is using direct. So exchanging directly from one to the other where there's a vendor assist, but you're not using an HIE, as we have come to call them. Or if you are actively participating in an HIE that's actually exchanging real data, that ought to be sufficient as well.

So you can do one or you can do the other. I think that simply was the thinking there, from my recollection, was that we want you exchanging data. And if you're doing it directly that should count, and if you're using an HIE, then that should count too. It was that simple. Now should that HIE in order to qualify under that criteria be sort of meeting the governance principles of NW-HIN? I don't think that's a bad idea, but I guess I'm still struggling with how else did you envision, let's call them qualified entities—

entities that have gotten the seal of approval and can use the NW-HIN brand—and that could be sort of any number of entities on the list. And I think Paul's right, they're not required to establish that they're good at what they do; they're only required to establish that they meet trust and interoperability criteria—at least based on my recollection of the governance principles that we adopted.

Deven McGraw – Center for Democracy & Technology – Director
This is one, again, we're bringing this to you guys to see if it's a good idea. So this is not a pet idea that anyone's trying to push. It's just this idea that came up. it made more sense to us in this broader kind of—I think, the thought was not that the NW-HIN directly makes you qualified to do this, but rather that might be a minimum bar. So there might be a way to link this to say, "If we're going to have a deeming process, at a minimum, you have to abide by those things."

In addition, you may have to even get certified with respect to whether you can do the XYZ thing that somebody wants to rely on you for, but Devin's absolutely right, to the extent that I want to exchange lab data. I want to have report quality measures. I want to do X. All these things I want to do. I can already ask somebody else to do that with, and, or for me. There are questions—I think we're going to have an increasing blurring of the lines between an EHR and an analytics function and a query function. All of these things are going to start looking increasingly confused.

The way I construct mine might be very different from the way you construct yours. So I do think we're going to have some questions around certification coming down the pike around, "Does that mean that all these other things become modules, so that it all gets packaged?" And it's not really in the insurance. So that's a much huger question. But we were not trying to say that if you're NW-HIN qualified that means you're automatically able to do these things. We're just trying to open up this question of these kind of external entities and whether we just let folks use them if they're going to use them and then they go through the certification that's required and we don't mention it, or whether we want to mention it in a more overt way.

Jonah Frohlich –HIT at California HHS agency – Deputy Secretary
This is Jonah. One way that maybe we can think about this because I think it's relatively important in coming from a state agency that was involved. There's a timing aspect to the state HIE program that was funded and the meaningful use program. In the state HIE program, the states are in the process of getting their strategic and operational plans approved, and are now going through a process of actually implementing their plans and over the course of the next one to two years are doing their procurement process and setting things up like their directories, NPIs and other services. By the time that that has happened and they are really able to exchange data and support providers and communities, the Medicare meaningful use program is, basically, going to be about to end in terms of the incentive payment. And so there's a real opportunity that has been lost to try to capture some of that HIE opportunity to help drive a $600 million taxpayer investment. And so some of these networks would likely—and some of these funded opportunities will likely languish because they're missing that load.

I think part of the opportunity here is to say that these are, in many cases, very new networks where their funding is still relatively nascent that works within these states. Give them a chance to try to build up their infrastructure by allowing early participants to connect to them in order to satisfy some of the meaningful use criteria, and build their capacity over time so that we can better align the timing of the meaningful use medical program and the HIE program. But without writing a blank check and saying, "Well just let them sign up, and you're fine", there should be some minimum criteria as to what those qualified networks can do. And I think the NW-HIN governance piece covers the governance aspects of it. But there should likely, I would suggest, be some technical and at least some functions that describe what those networks really need to do on behalf of the providers, whether it's actually supporting direct and/or supporting querying capability to get document summaries from EDs for example.

So I would suggest that this is an important concept. I think it's important to try it because we need to try to better align the HIE state programs with meaningful use programs, and to support a $600 million plus investment that's been made in those and give them a better opportunity of getting providers and hospitals to begin using the services that they're just beginning to put into place.

Paul Egerman – Software Entrepreneur
So the answer then if, I'm hearing right, the answer to Devin's question is what … is trying to solve is trying to solve a problem for startup HIE organizations to help them basically acquire participants? Is that what I'm hearing?

Jonah Frohlich –HIT at California HHS agency – Deputy Secretary
I would suggest that is one problem. But the other problem that it should be solving is that providers who use them in the long term will have robust HIE networks that will allow them to exchange information. So I think in the immediate term, it's trying to leverage an investment. But that's not the ultimate goal, that's an objective. The ultimate goal is to get robust HIE actually happening amongst providers and hospitals.

Paul Egerman – Software Entrepreneur
But the only thing they have to do is do a minimum set of interoperability and security in order..

Jonah Frohlich –HIT at California HHS agency – Deputy Secretary
Well, I would suggest that it probably needs to be staged, much like meaningful use is staged. We can't simply expect that you sign, for example, an agreement—a governance that describes a set of governance principles and fair information practices, which are required. But that has to be one step of many, and we probably have to consider how over time the requirements need to be considerably ratcheted up.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Peter and then Jim.

Peter DeVault – Epic Systems – Project Manager
So several things. I think it's important— I'm not opposed to the idea of a qualified entity, and I appreciate the way Claudia that you kind of hedged on what exactly it might even be, and that it's not necessarily a RIO or a repository or an RLS. I think it's important that a covered entity, as Paul said in his first comment, should also have the same sort of status as a qualified entity. There are many organizations today, we've got over 50 of them, mostly large IDNs, who are performing robust IHE with no intermediaries—doing what we called direct exchange before there was the direct project using the same standards as the NW-HIN and using the other IHE profiles. And they're also able to connect to the Metatech hospital down the street or …

W
They are an intermediary. I mean…

Peter DeVault – Epic Systems – Project Manager
No, no. There is no intermediary. Every healthcare organization connects directly with each other. Or did you mean the healthcare organization is the intermediary?

W
They're querying each other?

Peter DeVault – Epic Systems – Project Manager
Yes, there's nothing in the middle. And a lot of our customers are concerned, and I know it's not just our customers—are concerned when we see things like, maybe you have to be a qualified entity under NW-HIN because there's a frustration that NW-HIN might only recognize HIEs as things that can be directly gatewayed to the network, whereas in fact, these customers, these organizations are ready to be connected directly now. So to the extent that we're saying it's all an equal playing ground and that covered entities connect to each other and if they wish to, also connect to intermediaries—that's fine. I just want to not leave out the fact that there's robust HIE happening without intermediaries.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Okay. So Jim and then Hunt. And I would also like to just put a place holder, and I don't know Jim if you participated or not, but I know Hunt you did and Jonah, But the state HIE coalition actually has a very specific perspective on this that I'd love one of you to articulate just so all of us understand that. I don't know who that would be but go ahead.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Well we did sign onto that although Jonah or someone might be a slightly better person to articulate that particular letter. You know, I was thinking about why we might want to talk about this from a longer range perspective. And so to me it is all about push versus pull. So if what we really want for the exchange into the foreseeable future is pushing transactions where, "As long as I know where to push it, that's what I'm going to do." And the resources and what I need to do that is rather modest. I need some security credentials, and I need a provider directory, and probably that's about it. So that's one thing. If we want to go toward pulling where a patient might show up, and you want to try to identify where those records are throughout the system, you probably need master patient indices. You need HIEs or at least some of your resources connected in an integrated way. That's going to require a much greater trust framework, and for me, that strategy..

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
… more detail but those 50 some organizations that are connected to each other have a distributed entity-level provider directory, essentially, and connect directly with each other without a record locator service.

W
….

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Well we could probably explore that. I think some people are maybe a little skeptical about how you would do this at a large scale, but to me that's what this is about. And so if you want to support HIEs as a mechanism toward getting toward the ability to pull down the road, the question is, "Do you want to support them?" You've got $600 million going into the now. If it's going to be about push, then I don't really know why I should be supporting the HIEs in my state. That's not really what my strategy ought to be. I ought to take the money that I'm getting from ONC and put it into provider directories, master patient indices, and some type of database mechanism to manage patient consents, consumer preferences, moving forward. That would be a better strategy, but it's going to leave us kind of high and dry for HIEs on a more robust type of exchange strategy, particularly around pull.

So for me it's what is the longer range? How long are we thinking push is going to be the primary mechanism for exchange? And what should we be allocating our resources for? And in Minnesota we actually did pass a certification requirement that if you're facilitating the exchange of meaningful use transactions, you have to come get certified and essentially licensed by the state. And we look at a variety of things. We look to see that you are meeting all state and federal privacy requirements. We look to see that you're using national standards that are out there consistent with NW-HIN. We require you to communicate with anyone else that's certified in the state of Minnesota to be able to exchange any meaningful use transaction, as well as any record locator service information.

The main purpose behind that was really to ensure that when a provider signs up with someone who's doing meaningful use transactions, they can be resting assured that this person is going to meet their privacy and security needs, that their patient's data is going to be secure, and that they're not going to be connecting to an island. So if I connect to this particular HIO, I don't want to know that I can't exchange with Steven's hospital because they happen to participate with another exchange provider. So that's what we were trying to protect against. But again, that was much more thinking about pull in the near time. If that's not a reality, there are probably other directions that would be a better use of the funding that we get.

David Lansky – Pacific Business Group on Health – President & CEO

I am the co-chair of the statewide HIE coalition and my signature is on the letter. And actually I'm realizing—I'm going to distribute it to this group in a minute because I think it would be useful. And we also submitted a letter in comment on PCAST, and they are highly overlapping. That being said, my motivation is, because I started on HIT and health reform before HIEs were a formal program and thought, it's not that this is about supporting the business case for the state HIE program. I think this is about a much larger thing. It's really about building the infrastructure to support data exchange broadly and liquidity. It's not an either/or. It's an and ... I keep finding myself coming back to this statement that—and I'll make my usual disclaimer that I feel a little intimidated talking about information technologies design principles with people who are so much better skilled in this area than I am. But my sort of dumb way of thinking about this is we're building the distributed network of health information, then the characterizing principle of a distributed network is that all the nodes are equal. So the integrated delivery network, the HIE, the independent practicing doctor, like, we're looking to have a level ground among all these things.

I think that's part of where we've gone in the provider directory discussion the ELPD. You'll have ELPDs in big organizations and HIE, and it's going to be a distributed—already quickly going over my technical knowledge—but I think the point is that there are various resources out there, and lots of variability across states across how healthcare is organized and delivered in the country. Strangely enough, in Vermont, we don't have a single IDN. That doesn't exist there, which makes us a lot different than many other states. So part of the challenge that we face in thinking about how to scale the design of this huge distributed network system is accounting for that variability. And one lever and option that we have are these state HIE programs, and I don't think it's even—I'm confident it is not all of the 56 grantees—that would become qualified HIE networks. But I think that there's an opportunity to take advantage of that not just the—we keep talking about the half a billion dollars, and yes it's important, but it's like the time and energy and sunk investment human capital in all these is huge also. I mean amazing amounts of volunteer work in every state to move these things along these discussions right. So, I—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Could you just explain in two sentences what the proposal in the letter is? Because I'm not sure that everyone—

David Lansky – Pacific Business Group on Health – President & CEO
Yes. Thanks for focusing me. So specifically, I'm actually just going to summarize from the letter. So "the networks would develop, connect or otherwise utilize the CORE services, an authoritative provider directory, a service access layer consisting of a uniform transport protocol that supports a range of HIA transactions such as the delivery of patent summaries, lab results etc. Security services that allow system administrators to manage permissions, review rules, and ensure that only those with appropriate credentials and privileges can access supported HIE services." So as Jonah was saying, I think that this would be an evolutionary and iterative development of what constitutes—I mean, we couldn't even get agreement within our coalition of exactly how to define what these qualified entities would be. We left it kind of, you know, "and to be determined over time in an evolutionary sense." But our though was that you could start with some kind of floor that would come out of the FACA and ONC process, and then build on that to push along in concert with all the other kinds of efforts that are happening. The big long term vision of … I'll distribute these two letters, which are far more eloquent than I am.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Claudia, and then Jim again.

Paul Egerman – Software Entrepreneur
Could you put me in the queue? This is Paul.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes. Okay Paul. You're right after Claudia.

Claudia Williams – ONC – Acting Director, Office State & Community Programs

So one of the germs I take out of this conversation is the desire to push forward to the ability to discover patient information. I use meaningful use stage two to make progress towards that and I think the reality we're all living with is that I think it's pretty clear that that won't be available everywhere next year. And so one way to do that is the concept you describe, which is to say well there are certain entities and not every one of the grantees, by any means, are able to do that now or will be in six months or a year. But for where it exists to rely on it.

Another might be to say make it a menu set option to query a care summary at an ER but, find a couple places where you could say, "Here's a capability. Not everyone's going to have it. Not everyone can meet it. But where it exists let's allow for it." And as Deven said, there are a ton of policy questions we need to answer with respect to that. So I think it might be helpful to bring this down to this core desire, which is to make progress towards a set of capabilities we don't have universally and kind of encourage them along where they may be there or nascent or almost developed in a way that acknowledges this heterogeneity.

So are there, actually as … said right before he left said, "What's the down payment we can make in stage two towards this, …the same question, "What is the down payment we can make now?" How can we message in stage two that folks should—let's move along towards this, let's answer these questions. Let's make patient matching more accurate. Let's figure these things out. So are there other ways we could think about motivating towards that goal? I mean, this is one. And I think it's a very interesting proposal, but if that's our real goal, how can we get there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Paul and then Hunt and then Walter.

Paul Egerman – Software Entrepreneur
Yes. First to respond to Claudia's question of how we can get there, I think the way we get there is to get there. To say sort of focus on the problem that we're solving in terms of what people are calling poll transactions, or query/response that deal with the privacy and security, and to define what our solutions are going to be—that's how we get there. I just don't see how establishing a new staff and governance status called qualified HIEs necessarily gets us there. I don't get that. And then the previous speaker, I think it was Hunt, said that all the nodes are equal, and I just had a couple of observations about that.

One is that the nodes really aren't equal because there's a difference between a business associate and a covered entity. So HIEs are not equal to the covered entities. But if they were equal—I'm trying to understand, does the HIE coalition's proposal include the covered entities? In other words, can, say in Vermont, could Fletcher Allen or Hitchcock Clinic become a qualified entity in the same way that the Vermont HIE can?

David Lansky – Pacific Business Group on Health – President & CEO
In Vermont, the legislature determined that we have one, in a smaller scale than what Jim did, that we have one statewide HIE. It doesn't preclude their being other entities running their own exchange. So I think that you could. Yes, that would be possible. To your correction about equal—this is again part of my technical limitation. The point that I'm making is metaphorical more than specifically technological, in the sense that the—if the idea of the various players in healthcare, patients doctors, hospitals, are on an even setting in the same way that the various players in the Internet are on an even set—you can click from the Morrisville transcript to the New York Times without having to go through some—it's flat in the relationships. Right? So my point is that we don't need to have a privilege of hierarchy of health institutions large that have more resources versus the being players in this data stream where individuals with their PHRs, small practices, big practices, it's a bigger discussion there. Let's park that.

Paul Egerman – Software Entrepreneur
Actually that's very helpful. I did not understand what you were saying, and now i do understand that part. So thank you.

David Lansky – Pacific Business Group on Health – President & CEO
Did I interrupt? Do you have more that you wanted to say Paul?

Paul Egerman – Software Entrepreneur
No that was it thank you.

David Lansky – Pacific Business Group on Health – President & CEO
I put my card up because I thought that maybe the one way to clarify this also was to hearken back to our previous discussion about quality metrics and about the sort of larger point—about where we're trying to go with all of this in terms of moving from the current volume based—what we, I think broadly, is agreed is not a sustainable business model for healthcare—our payment structure and moving to a value based structure and that. In order to do that we need sufficient data around which to have metrics that we can agree are the right things to pay on.

And so part of what we need not just within the context of— you can do it inside an individual IDN because it's a closed universe. But looking across the broad healthcare system, again Vermont's an easy example for me because I know it, we don't have that big system. But it's sort of a microcosm of the whole country because we've got—you can just think of lots of big Kaiser's just another practice in the big scheme of things in the metaphorical flat thing that I'm talking about. So I think what we're looking for is a path towards a both a technology platform and a governance platform that enables the data to flow freely. So sorry if this is like gone off in abstract land.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We had Walter, and then Steve

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
You know, all this discussion just reminded me of an old hat that I used to wear and that's the HIPAA transaction and of course I still wear it actually sometimes. But with HIPAA the concept, as many of you know—and this is HIPAA not the HIPAA privacy part. But HIPAA the other part, which is transactions and all this, that there were the providers and the payers and in the middle was this thing called clearing houses. And the clearing houses were basically the ones—the mechanisms that many today even used to exchange the data.

So my system can't produce really a transaction like a claim in a standard form. So I gave it to the clearing house, I gave it in different formats, even ASCII flat files or whatever, and then they convert it into the standard and then send it to the recipient—the payer or the payer of claim. And then it still works today and it still serves as a mechanism to allow people to meet this requirement and to exchange the data for administrative transactions and all that. This concept of qualified entities with respect to EHR and with respect to HIE exchanges kind of expands that into, yes, there will be this entity in the middle that would allow that. I will support that exchange and will serve as a mechanism to increase the exchanges which is, in my mind the goal that we have.

The real challenge is defining all those characteristics that the qualified entity needs to meet. And I know that there are regulations in some states that are defining those and—but in my mind the ultimate goal we should look for is optionality and flexibility. I think creating an option is good; limiting that to be the only option is probably not good.

And I know that's probably not the intent here, but it should be a clearly stated goal that if we were to go down this route of identifying qualified entities to support … for doing information exchange, one of the principle should be this—which should be an option and a way to do it. Just like there might be other mechanisms to do it. So I just wanted to introduce that as kind of a principle, a goal that this should be seen as an option and the principle of optionality and flexibility should apply to this as well, and should not be something that is be a required mechanism to do.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. I've lost track of who was speaking next. Oh, the one with the tent up I guess. I was looking at the Dave Guess nametag and didn't

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So if anyone other than Paul's on the phone still this is Steve Stack. I guess I admit to just a little bit of confusion in a little bit in a lot of different ways. The internet works and it was never—I don't think anyone funded seed money to make it work, and I can go to web pages and exchange information and I can find addresses and search things. So I know HIEs are one way where you can bring together disparate sources of data and have them find each other and share things.

I think the PCAST Report envisions a very different way where things are distributed differently and you can kind of search the universe somehow and find these metadata tags and find your information and pull it down. And then there are instances where say you were a rural community with one hospital, and if there were stark law changes and things like that, it may be that in that area the hospital essentially becomes the information hub for the community for hundreds of miles around it—or 50, 80 miles around it. And then there's opportunities where all politics is local and most healthcare is local. Where the local community may come together to create its own version of an HIE that may be the three main hospitals and the large groups and then all the other little onesie, twosie, and fivesie groups just sort of say, "Hey this is already ready-made. I'll just link on as a node to that."

And so I guess what I have a hard time conceptualizing is does this give a nod to or a leg up to one of many options that could be out there. And ultimately what will have to happen over time, and there may need to be seed money in certain areas to get certain concepts far enough down the path to find out if they're good or not, but on the other hand all of this will have to survive under its own business model going forward. And so I guess I don't know if defining a qualified entity and what—I just don't know how much that helps or doesn't help because ultimately if I use the qualified entity, they may have the ability for me to exchange information and get care summaries and pull down fill histories for medicines and things like that. But ultimately it's the eligible provider; I'm going to have to have to be the one that attested that I actually used it. It won't be sufficient to say I've contracted with so and so because if that was good enough then you could have people who free ride and never use it but just say, "I can." So I'm not sure that—I mean, I guess a little more clarity on how this would specifically advance or help would help me, and I guess I'm confused in that regard.

Deven McGraw – Center for Democracy & Technology – Director
I think one of the—in my view—a value to having an entity who is providing some assistance in exchange be somehow vetted for or held accountable to a set of policies is largely on the privacy and security side. Because we've got the HIPAA regulations that provide a baseline, and state law requires something above that for many participants, although not necessarily all. It depends on where you are. But in terms of the sort of operational best practices and policies that go beyond what the law requires, I know personally that I thought that creating some standards that people would ascribe to or need to ascribe to as part of the NW-HIN was very appealing. So that doesn't address the issues that Paul Egerman raised about whether this entity that you have chosen to use to help you meet meaningful use is actually good at what they do, but it does address whether in fact they have agreed to and agree to hold themselves accountable to complying with a set of baseline policies.

So I've actually been enthusiastically anticipating this governance rule looking for that very thing. But I think there are—we shouldn't look to governance as sort of the be all and end all, but it is a vehicle for setting forth a set of minimum standards and criteria that we might want to make sure that entities that are part of this process. It's not limited to whether you call them intermediaries, assistors, HISPS, HIEs, RIOs, vendors—but certainly if I hearken back to what came out of the Governance Workgroup and what the Policy Committee endorsed, it would give sort of an—if you're in the health IT ecosystem and you want to be exchanging using the NW-HIN brand. There's a place for you to join this as long as you agree to be bound by a certain set of requirements. So that's my recollection. That's what I thought the value was. It's if we're going to set some best practices that go above and beyond what the law requires, what's our vehicle for propagating those forward. And I think a lot of us thought it could be NW-HIN. We don't know what it's going to look like yet so.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Not been clear at all that an IDN or a covered entity could ever become a qualified entity under NW-HIN. That's never been made clear. What is clear is that if and HIE or some other thing is sponsored by a federal agency, then you can get in the process to become qualified. What I don't want to have happen, and I agree with you that something like the NW-HIN governance trust fabric would make sense for these qualified entities, but if in fact it turns out that only certain kinds of things can actually qualify, then maybe it's not the best vehicle.

Deven McGraw – Center for Democracy & Technology – Director
... one is that this is a rule-making process that will have lots of opportunity as we always do for public input. I don't think it's publicly, I don't think you should look at what's happened in the past under NW-HIN exchange unboarding as an indication, that's a set of things that have come before. But going forward, I think there is this broad conception that these are participants and exchange and that there'll be a variety of different folks, and it's more on related to what kind of functions you're performing unless this kind of entity with this kind of funding or this kind of thing. So I think that's the general framing that at least is the going in assumption from the workgroup that put forward the set of recommendations. But there will be lots of chance for input as we go forward with it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, Jim

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Well a couple of quick things. Peter, to one of your questions, in Minnesota, a large integrated system certainly could become certified. They would just have to meet the same requirements as an exchange. So, in Minnesota that would be under Minnesota governance. So in our model that would be absolutely feasible. But I think to Steven's question, your question was kind of, "How might this help me. What difference does this make?" Was kind of what I took. And I think that for me, again, because we have a very specific task, it's actually spending the money to support exchange. And I want to figure out the best way to do that. And so to me I think the question is at some point we want to be able to find the patient's records and do those types of queries, and so one way would be to do it is through HIEs, which in Minnesota we do that and regulate. And if providers are required to connect to them, that is likely to be the mechanism by which we both create the HIEs record locator service, and ultimately require those different HIEs that might get certified to come together with essential ones.

So my mechanism for figuring out how to get a single state solution is going to go through those HIEs which I currently regulate. If on the other hand, it's going to be a different model where no, it's going to be primarily direct and a better way to put our resources would be to create directly a state faster patient index record locator service, then my suggestion would be instead of saying that providers should connect to an HIE—one of the requirements around meaningful use is you should be required to contribute information to a record locator service that is connected into the broader NW-HIN.

I think both of them are viable models, but they require different time, effort and resources and commitment from the stakeholders, and so one of the challenges sitting down at the state is both good models. But I've got to kind of have some sense of which direction to go. And this is one of the primary vehicles that are driving provider behavior, and so if this is what's going to drive the provider behavior, it needs to help me understand where I should be moving on exchange, and where to commit the resources and building the tools to help do that. And it's not clear to me that depending on what goes into this it doesn't change what I might do.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
I think there is. I guess I was just going to say that it seems like there is a fundamental question here that's underlying a lot of the conversations around this about whether we would want to have any meaningful use requirement that requires an individual entity—whether it's a provider or hospital to use an intermediary.

Jonah Frohlich –HIT at California HHS agency – Deputy Secretary

I don't think there first of all is—unless the whole rule making process defines a governing entity set of requirements, and almost anybody can be one, and we can get there soon enough. I'm not sure that having that as a requirement might be as appropriate as making it an option, which I think, Steve, was one of your points. And again, an option would allow for those regions that have the infrastructure in place, whether it's a regional, a state HIE, an IDN, a private network, whatever, to be able to support the necessary functions. But where there are no minimal infrastructure and no governance overseeing regional exchange, then I would be pretty hard pressed to require anybody to participate in something that doesn't exist.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. So let's go back to our queue. Sid, then Hunt and Walter.

Sid Thornton – Intermountain Healthcare – Senior Medical Informaticist
Yes. Just briefly I wanted to augment what James is saying. In our community we really look to the query or the pull functionality as the incentive for our sustainability model. And when we think about issues of governance, and certification or qualification of these intermediaries, we want to ensure that we have a single point for issues such as collecting and enforcing the patient preferences for consent, for example, so that that is interoperable among all participants. So you're only hitting the patient once—and also for issues of exception management and repair service. We find a significant amount of work in going and repairing what the automation has gone awry. So we want that to be single-point.

Hunt Blair – OVHA – Deputy Director
So two quick points. One with respect to sort of how this ties, I think that meaningful use is an accelerator, it's not the end-state. Right. So we're part of the notion of using these qualified HIEs or qualified entities to help move us towards that future state where we have an ecosystem where query/pull etc. is all routine and possible. So that's one important distinction. And then also just to observe that it's kind of ironic that, don't mean to pick on you Peter, but representing IDN, IDNs are worried that government supported HIEs will have a monopoly on getting in on this whereas sitting around with my HIE colleagues, we're worried about not being able to swim in the big ocean with IDN. So I think this is another not either/or, but and/both situation where if we're look far enough over the horizon at the data liquidity ecosystem that we all want, then it's going to take all of us rowing ultimately in the same direction to get there.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Walter? And just a time check here, I think we're going to just have about five more minutes and then we have to turn to the public comment.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, I just wanted to say I think to your point Mick about the fundamental question. I think we have more of a consensus around the fact that this should be not really a requirement but an optional way of achieving health information exchange, meeting the requirement of health information exchanges. So I think we are generally from what I heard we're in very good consensus of this is a possibility and it should be considered an option. In fact going back to the perform test of HIE requirement that we talked about earlier before lunch. This is the kind of element that can be inserted there because this relates specifically to that particular measure of performing a test of HIE. Ultimately I do think as it has been said several times probably that clearly the goal of stage two and stage three even is increase the information exchange. That's clearly a goal. It seems like not only we're trying to do it through all this other requirements of doing the prescribing and doing care coordination, transition of care and all these things. But here we are concretely establishing a requirement that there needs to be exchanges be done you could meet them in different ways and this would be one of the ways. So I just wanted to point that out. I think it's more of a consensus that we have around this as an option how it gets defined and what is a qualified entity and all this is something that of course needs to be defined but clearly is an option.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
As an option I guess I'd also heard with a focus on functions and not about who the organization is. To the extent that if you want to use Epic care everywhere or you want to use the Indian alpha information

exchange or you want to use a HISP that isn't yet defined. That is something that the physician is attesting to using to perform a specific set of functions. And these other issues about what governance would be about a qualified entity really is sort of a whole separate conversation that isn't about the meaningful use transactions, which I think is what brought us here because it came through as one of the stage two meaningful use recommendations that you could check off the box with an entity. I think what I'm hearing is that it's not quite as easy as that and we need to at least for that to answer that question we need to sort of give them that feedback, but it's not quite as easy as that, there may be other issues there that are in other conversations.

Sorin, and was there someone else? Oh, and Paul. Okay Sorin and then you Paul. Oh okay, Sorin was just playing with his hand Paul. Paul?

Paul Egerman – Software Entrepreneur
Yes, I was confused by what Walter just said because I don't think there's consensus here at least I personally don't think that it should just be an option that if you connect to a qualified HIE that you're done. You don't have to do anything else, and I don't Micky you mentioned like … and … HIE, to me those don't belong together at all so I'm sort of confused by all of that. And so I don't understand, still goes back to the basic thing is I don't understand what problem we're trying to solve here in meaningful use, other than the comment I heard from Jonah is he wanted to try to get support for the somewhat startup HIE organizations.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
... just clarify very quickly because it's Paul—what I was trying to say is not just by virtue of connecting, it's clearly in the language of the measure on perform test of HIE is establish an ongoing bidirectional connection to a health information exchange. So one way is through a qualified entity or with a qualified entity or something like that. So it's really not just connecting, it's establishing that ongoing bidirectional connection in performing those kind of exchanges that are required under the regulations.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there any other thoughts? I'm not even going to pretend to try to wrap up this part of the conversation except to say I think it was a terrific conversation. I think we do in a lot of these different venues. One thing that Devin had pointed out is that in the HIE Workgroup about a year and a half ago, we're having really sort of the same conversation in many ways, which is just to point out not that we're not making progress along a number of dimensions, but this is a particularly vexing problem. I think no matter how we sort of approach this whether it's sort of the old RHIO concept or we start thinking about HIEs or you have PCAST, thinking of DEAS or indirect talking about HISPS you always come back to this question of intermediaries performing some type of function. And people trying to get their arms around what that would mean and whether they need to be sort of have a governance process around them or not. But let me pause here and thank everyone first off for spending an entire day with a lot of energy all the way to the end.

I really, really appreciate it and I think we had some terrific conversations. Actually made a lot more progress in the way of framing a whole bunch of these things that'll give us a little bit of structure to a nice set of recommendations that we'll be able to ride on April 5th, which isn't to say that we don't have work between now and then because we do. So I think David and I, and I'll try to much as much I can onto David, but I'm joking, but David and I will try to crystallize this and then feed it back to all of you as follow-up so that we have something documented that we can all react to. There'll certainly be some open areas that require a little bit more work and we can decide how far we want to go in the way of providing some feedback between now and April 5th, and which of those things we want to drill down further on post April 5th as that process unfolds. David do you have any other comments on this?

David Lansky – Pacific Business Group on Health – President & CEO
Good summary.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great. Thank you. Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
... how many of our public have stayed with us. And just a reminder to the workgroup, your next call is March 24th. So operator is there anybody who wishes to make a comment. There's someone on the line? No one. Well we outlasted them. Thank you all.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you Judy.